ORTHOPAEDIC TLC PATIENT MEDICAL HISTORY

TODAY'S DATE: ___/___/___ APPOINTMENT WITH: _____

PATIENT NAME: _____ DATE OF BIRTH: ___/___/___ AGE_____ ☐ Male ☐ Female

HOME PHONE:(___)____-____ CELL PHONE:(___)____-____ ER CONTACT/PHONE:_____(___)____-____

WHAT IS YOUR MAIN PROBLEM TODAY? _____ Left / Right

HAVE YOU HAD X-RAYS DONE FOR THIS PROBLEM? Yes / No If so, where: _____

REFERRED BY: _____ WHO IS YOUR PRIMARY CARE DOCTOR?_____

DESCRIBE IN DETAIL WHAT KIND OF WORK YOU DO: _____

DATE OF INJURY or when problem began: ___/___/____ Work injury: ☐ yes ☐ no HAND DOMINANCE: ☐ right ☐ left

HOW DID INJURY OCCUR? _____

DURATION OF PROBLEM:_____ PAIN LEVEL ON SCALE 1-10 (WORSE) 1 2 3 4 5 6 7 8 9 10

PLEASE CIRCLE ONE THAT DESCRIBES THE QUALITY OF YOUR PAIN: dull sharp throbbing achy stabbing shooting

IS THE PAIN: constant intermittent HOW IS THE PAIN WITH ACTIVITY: worsened improved unchanged

MEDICAL HISTORY Antecedentes Medicos	FAMILY MEDICAL HISTORY Antecedentes Medicos Familiares	SOCIAL HISTORY
☐ Cancer ☐ Heart Disease/Enfermedad delCorazon ☐ High blood pressure/Alta Presión ☐ Easy bleeding/Desangramiento ☐ Blood clots/Coagulo ☐ Stroke/Derrame cerebreal ,embolio ☐ COPD/Enfermedad pulmonary cronica ☐ Pulmonary embolus/Embolio Pulmonar ☐ Emphysema/Asthma ☐ Diabetes ☐ Stomach Ulcers/Ulceras del estomago ☐ Reflux or Hiatial Hernia/ hernia de hiata, reflujo ☐ Osteoporosis ☐ Thyroid problems/problemas con el tiroides ☐ Any other serious illnesses/otras enfermedades serias-_____	☐ Heart Disease/enfermedad del corazon ☐ High blood pressure/alta presion ☐ Stroke/derrame cerebral ☐ Blood clots/coagulos ☐ Bleeding problems/problemas con desangramento ☐ Diabetes ☐ Asthma/asma ☐ Pulmonary embolus/embolio pulmonar ☐ Cancer ☐ Osteoporosis ☐ Any other serious illnesses/otras enfermedades serias _____	Current smoker ☐yes ☐no ☐past If yes, how many packs per day?_____ Drug use: ☐past ☐current ☐never Oral tobacco use: ☐yes ☐no ☐past Alcohol use: ☐yes ☐no ☐pasts If yes, average amount per day_____ Dominant hand: ☐ left ☐right Marital status:_____ Weight_____Height_____ Lives with _____ Living will ☐ yes ☐no

+

PLEASE LIST ANY SURGERIES THAT YOU HAVE HAD IN THE PAST:_____

_____

LIST CURRENT MEDICATIONS:

1) _____ 4) _____ 7)_____

2) _____ 5)_____ 8)_____

3) _____ 6)_____ 9)_____

REVIEW OF SYMPTOMS

GENERAL	EYES	EARS	CARDIOVASCULAR	RESPIRATORY
☐ fever	☐ Worsening vision	☐ hearing loss	☐ chest pains	☐ cough
☐ Chills	☐ Blurred vision	☐ ringing in ears	☐ palpitations	☐ shortness of breath
☐ Sweats				
☐ Fatigue				
☐ Weight loss				
GASTROINTESTINAL	**GENITOURINARY**	**MUSCULOSKELETAL**	**SKIN**	**NEUROLOGIC**
☐ rectal bleeding	☐ painful urination	☐ low back pain	☐ rash	☐ vertigo
☐ diarrhea		☐ limb swelling	☐ sores	☐ short involuntary movements
☐ constipation				☐ failure of muscle coordination
				☐ numbness/tingling
PSYCHIATRIC	**ENDOCRINE**	**HEME/LYMPHATIC**	**ALLERGIC/IMMUNO**	
☐ anxiety	☐ excessive thirst	☐ abnormal bruising	☐ hives	
☐ uncontrolled emotions	☐ muscle weakness	☐ easy bleeding	☐ persistent infections	
☐ depression	☐ loss of hair	☐	☐	

 HEIGHT:_____ WEIGHT:_____ ALLERGIES:_____