WELLINGTON® ORTHOPÆDIC & SPORTS MEDICINE

PATIENT HISTORY FORM

(If seen within one year, please list changes)

Date:	
D.O.B	
S.S.#	
Age	
Gender	Male Female
Marital Status	S M D W

NAME (print)

Referred here by: (circle one) self family friend doctor attorney

other health professional

Name of Person/Physician making referral:

Primary Care Physician/Family Doctor:

Please describe the reason for you visit: Body Part right left both

Acute Injury - new (circle one) yes no Chronic Symptoms - old (circle one) yes no

How did your symptoms begin? If sudden, describe onset:

On scale of 1-10 (10 being most severe) circle # that best describes your pain 1 2 3 4 5 6 7 8 9 10

Approximate date symptoms began or date of injury:

Resulting from: (circle which applies) Sports Accident Work Related Involving litigation

Are symptoms constant intermittent worsening improving

Check all that apply pain stiffness swelling instability weakness numbness/tingling

What makes symptoms worse?

What makes symptoms better?

What previous or formal treatment have you had? (medications, therapy, surgery, injections)

Were previous treatments helpful to any degree? If so what?

PAST SURGICAL HISTORY AND/OR HOSPITALIZATION

Previous: Type of Operations or reason for Hospitalization	Year
1	
2	
3	
4	

Any previous fractures? yes no

Any other serious injuries? yes no

MEDICATION INFORMATION

Allergic to Latex? (circle one) yes no

Drug Allergies: Do you have any drug allergies? (circle one) yes no

If yes name the drug and the type of reaction. (example rash, nausea, etc) PLEASE BE SPECIFIC.

Current Meds: (List any medications you are taking at this time. Includes such items as aspirin, vitamins, laxatives, calcium, etc.)

Name of Drug	Dose (include strength and number of pills per day)	How long have you taken this medication?	Please Check: Helped?		
			A lot	Some	Not At All
1					
2					
3					
4					
5					
6					

PLEASE TURN OVER AND COMPLETE MEDICAL HISTORY

MEDICAL HISTORY/REVIEW OF SYSTEMS

Please check if you have had a history of any of the following:

	YES	NO		YES	NO
GENERAL			**CARDIOVASCULAR**		
Are you currently pregnant?			Chest pain, Angina		
Diabetes			Heart Attack, Myocardial Infarction		
Stroke			Palpitations		
Kidney Disease			High Blood Pressure, Hypertension		
Ulcers			Shortness of Breath		
Asthma or Lung Disease			Ankle Swelling		
Cancer TYPE:			**HEMATOLOGIC**		
Fatique			Anemia		
Weakness			Blood clots		
Fevers			Bleeding tendency		
Skin Problems/disorders TYPE:			Easily bruised		
Rheumatic Fever			Circulatory problems		
Tuberculosis			Blood thinners (currently on)		
Recent weight loss/gain. How Much?			(if yes, type?)		
BLOODBORNE PATHOGENS			Phlebitis		
HIV/AIDS			**MUSCULOSKELETAL**		
Hepititis			Joint Pain		
Other			Joint Swelling		
SITES OF INFECTION			Muscle weakness		
Urinary			Muscle tenderness		
Dental			Morning Stiffness		
Other			Arthritis/Osteoarthritis		
NEUROLOGICAL			Rheumatoid Arthritis		
Headaches			Bunions		
Dizziness			Osteoporosis		
Fainting			Previous bone density test?		
Memory Loss			Bone/Joint infections		
Loss of consciousness			Gout		
Muscle spasms			**PSYCHOLOGICAL**		
Numbness or tingling of hands/feet			Depression		
Blindness or trouble seeing			Anxiety disorder		
Deafness or trouble hearing			Other		
Seizures					

Other illnesses or diseases which are not listed? Please describe

FAMILY HISTORY

Please check if any of your family (parents, brothers, sisters, grandparents) have a history of any of the following:

	YES	NO		YES	NO
Diabetes (sugar)			Abnormal bleeding tendencies		
Heart Disease			Rheumatoid Arthritis		
Anesthetic complications			Osteoarthritis		
Cancer TYPE:			Gout		

SOCIAL HISTORY

What is your approximate weight? Lbs. Height? Ft. In. Shoe size BMI (doctor use)

Occupation No. of years Job Duties

Do you smoke? (circle one) yes no past If yes or past, # of packs per day, # of years

Are you (circle one) right handed left handed

Do you consume alcohol? If so how many drinks per week? Is there history of abuse? (circle one) yes no

Have you ever had a problem with drugs? (circle one) yes no

Do you participate in recreational drugs? (circle one) yes no past If yes or past, list type and amount.

Do you regularly wear your seat belt? (circle one) yes no

Please list all sports and hobbies you are involved in:

What is your principle support system? Example Spouse, Family, Friends, Church

I, as the patient, state the information is correct and accurate to the best of my knowledge. ***(patient signature) Date:***

I have reviewed this information with this patient. ***(M.D. signature) Date:***