ORTHOPAEDIC SPECIALISTS OF AUSTIN

MEDICAL HISTORY – GENERAL

PATIENT NAME:				DATE:
Pharmacy Name & Location:			Primary Care MD:	
Date of Birth:			Patient Address:	
Weight:	Height:	Age:		
☐ Left-Handed ☐ Right-Handed			Patient Phone:	

HISTORY OF PRESENT ILLNESS

Describe the reason for your visit:

Date of Injury:	How did this injury/condition occur?

EVALUATION OF PAIN/DISCOMFORT

What body part(s) is/are affected?
What makes it feel better?
What makes it feel worse?
What does the pain keep you from doing?

PREVIOUS TREATMENT FOR THIS PROBLEM

Diagnostic Testing/Facility location:	CT ☐	MRI ☐	EMG ☐	X-ray ☐	Other ☐
Anti-Inflammatories:	☐ Helpful	☐ Not Helpful		Other Treatment:	
Injections:	☐ Helpful	☐ Not Helpful			
Physical Therapy:	☐ Helpful	☐ Not Helpful			

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PAST MEDICAL HISTORY (check all that apply)

☐Diabetes	☐Bleeding tendencies	☐HIV / AIDS
☐High blood pressure	☐ Blood clots	☐ Hepatitis
☐Stroke	☐ Cancer	☐ Vascular disease
☐ Heart disease	☐ Ulcers	☐ Anesthesia difficulties

PAST SURGICAL HISTORY

Describe:	Year:	Describe:	Year:
Describe:	Year:	Describe:	Year:
Describe:	Year:	Describe:	Year:

CURRENT MEDICATIONS (List medications or give a list to your health care provider).

Medication Name	Dose	How often	Medication Name	Dose	How often

ALLERGIES(medications, metals, etc.)

List :

FAMILY HISTORY (check all that apply)

☐Cancer	☐Diabetes	☐Musculoskeletal disease
☐Heart disease	☐ Malignant hyperthermia	☐ Anesthesia difficulties
☐ Stroke	☐ Bleeding disorder	

SOCIAL HISTORY (check all that apply)

☐ Married	☐ Single	☐ Divorced	☐ Widowed
☐ Live Alone	☐ Live with Family	☐ Live with Friends	☐ Live in Nursing Home

Do you smoke?	☐ Yes	☐ No	How many years?		How many packs/day?	
Do you drink?	☐ Yes	☐ No	How often?	☐ Minimal	☐ Moderate	☐ Heavy
Your occupation:					Last day worked:	

REVIEW OF SYSTEMS (check all that apply)

Skin	☐Rash	Throat	☐Sore throat	GI	☐Weight loss or gain
	☐ Psoriasis		☐ Hoarseness		☐ Abdominal pain
Hemo	☐ Bleeding tendencies		☐ Snoring		☐ Liver disease
	☐ Bruise easily	CV	☐ Heart attack		☐ Constipation
Eyes	☐ Visual Loss		☐ Irregular Heartbeat	GU	☐ Kidney stones
	☐ Double vision		☐ Chest pain or pressure		☐ Bladder infections
Ears	☐ Decreased hearing	Lungs	☐ Shortness of breath		☐ Blood in urine
	☐ Ringing in ears		☐ Asthma	Endo	☐ Diabetes
Nose	☐ Sinus problems		☐ Bronchitis		☐ Thyroid
	☐ Breathing problems		☐ Pulmonary emb/DVT	Skeletal	☐ Osteoporosis
Psych	☐ Depression	Neuro	☐ Seizures		☐ Rheumatoid Arthritis
	☐ Hallucinations		☐ Headaches		☐ Gout