ORTHOPAEDIC SPECIALISTS OF AUSTIN

MEDICAL HISTORY – GENERAL

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

HISTORY OF PRESENT ILLNESS

Describe the reason for your visit:

Is this the result of an injury? ☐ YES ☐ NO	Date of Injury:	Location of Injury:
	How did this injury occur?	

EVALUATION OF PAIN/DISCOMFORT

What body part(s) is/are affected?

When did the problem start?

What makes it feel better?

What makes it feel worse?

How long does your pain last?

Pain Scale (Circle one number)	Mild				Moderate				Severe	
	None 1	2	3	4	5	6	7	8	9	10

Is your pain activity-related?	☐ Yes ☐No	Does pain wake you from sleep?	☐ Yes ☐No

What does the pain keep you from doing?

PREVIOUS TREATMENT FOR THIS PROBLEM

Diagnostic Testing:	☐ CT	☐ MRI	☐ EMG	☐ X-ray	☐Other
Anti-Inflammatories:	☐ Helpful	☐ Not Helpful	Other Treatment:		
Injections:	☐ Helpful	☐ Not Helpful			
Physical Therapy:	☐ Helpful	☐ Not Helpful			
Chiropractic's:	☐ Helpful	☐ Not Helpful			
Acupuncture	☐ Helpful	☐ Not Helpful			
Is this condition being covered by Worker's Compensation?			☐ Yes	☐ No	
Is there a lawsuit or litigation pending in regard to this condition?			☐ Yes	☐ No	

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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 (Please list all prescription and non-prescription medications that you are currently taking).

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


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