

**EAST COAST ORTHOPAEDICS  
PATIENT HEALTH INFORMATION**

**PLEASE PRINT**

DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**\*ANSWER ALL QUESTIONS\***

PATIENTNAME \_\_\_\_\_ AGE: \_\_\_\_\_  RIGHT-HANDED  LEFT-HANDED

REASON(S) VISIT \_\_\_\_\_

LIST CONTRIBUTING EVENTS OR KNOWN CAUSES FOR SYMPTOMS: \_\_\_\_\_

HOW LONG HAS SYMPTOMS BEEN PRESENT (Or date of injury?) \_\_\_\_\_

DO SYMPTOMS INCLUDE PAIN?: Yes  No  (If yes, check all that apply with severity of pain)

SEVERITY OF PAIN: Circle rating of 1-10 for severity of symptoms with 10 being the worst

Sharp      1 2 3 4 5 6 7 8 9 10       Dull      1 2 3 4 5 6 7 8 9 10

Burning      1 2 3 4 5 6 7 8 9 10       Stabbing      1 2 3 4 5 6 7 8 9 10

FREQUENCY OF PAIN:       CONSTANT     INTERMITTENT     PROGRESSIVE       NOT PROGRESSIVE

DO SYMPTOMS INCLUDE?     SWELLING     WEAKNESS       NUMBNESS

DECREASED RANGE OF MOTION     PINS/NEEDLES SENSATION

IF APPLICABLE, IS THE JOINT?     POPPING     LOCKING     CLICKING     INSTABILITY/GIVING WAY

WHAT ACTIVITIES WORSEN YOUR CONDITION? \_\_\_\_\_

**PAST TREATMENT OF YOUR CURRENT PROBLEM?** (Check all that apply)

ICE TREATMENT     PHYSICAL THERAPY     INJECTIONS (How many?) \_\_\_\_\_

HEAT TREATMENT       REST (Specify amount of time) \_\_\_\_\_

RELATED PAST SURGERIES? (Specify with dates) \_\_\_\_\_

**MEDICATIONS YOU ARE CURRENTLY TAKING** (List) \_\_\_\_\_

**DRUG ALLERGIES** (List) \_\_\_\_\_

**MEDICAL HISTORY**    **HAVE YOU BEEN DIAGNOSED TO HAVE ANY OF THE FOLLOWING?** (Check all that apply)

- |   |   |
|---|---|
| <input type="checkbox"/> ALCOHOLISM   | <input type="checkbox"/> HEART DISEASE <input type="checkbox"/> Mitral Valve Prolapse <input type="checkbox"/> Murmurs                    |
| <input type="checkbox"/> ARTHRITIS (Location) _____   | <input type="checkbox"/> Abnormal Rhythm <input type="checkbox"/> Congestive Heart Failure  |
| <input type="checkbox"/> ASTHMA   | <input type="checkbox"/> HEPATITIS  |
| <input type="checkbox"/> BLOOD CLOTS  | <input type="checkbox"/> HERNIA <input type="checkbox"/> Inguinal <input type="checkbox"/> Hiatal   |
| <input type="checkbox"/> BLOOD DISEASES <input type="checkbox"/> Anemia <input type="checkbox"/> Leukemia | <input type="checkbox"/> HIGH BLOOD PRESSURE  |
| <input type="checkbox"/> BLOOD TRANSFUSION (When) _____   | <input type="checkbox"/> HIGH CHOLESTEROL   |
| <input type="checkbox"/> BRONCHITIS   | <input type="checkbox"/> HIV POSITIVE   |
| <input type="checkbox"/> CANCER (Type) _____  | <input type="checkbox"/> KIDNEY DISEASE <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Kidney Cysts                      |
| <input type="checkbox"/> CATARACTS  | <input type="checkbox"/> LATEX ALLERGY  |
| <input type="checkbox"/> COLITIS  | <input type="checkbox"/> LIVER CIRRHOSIS  |
| <input type="checkbox"/> DIABETES   | <input type="checkbox"/> PARKINSONISM   |
| <input type="checkbox"/> DIVERTICULITIS   | <input type="checkbox"/> PEPTIC ULCERS  |
| <input type="checkbox"/> DRUG ADDICTION   | <input type="checkbox"/> PROSTATE <input type="checkbox"/> Enlarged <input type="checkbox"/> Inflammation <input type="checkbox"/> Cancer |
| <input type="checkbox"/> EMPHYSEMA  | <input type="checkbox"/> PSORIASIS  |
| <input type="checkbox"/> EPILEPSY   | <input type="checkbox"/> STROKE   |
| <input type="checkbox"/> FRACTURES/BROKEN BONES (Where?) _____  | <input type="checkbox"/> THYROID DISEASE  |
| <input type="checkbox"/> GLAUCOMA   | <input type="checkbox"/> OTHER _____  |
| <input type="checkbox"/> GOUT   |   |

**(PLEASE TURN OVER AND COMPLETE BACK SIDE)**

**PAST SURGERY** (Check all that apply)

- APPENDECTOMY
- ARTHROSCOPY
- BACK SURGERY
- BREAST SURGERY
- CATARACT SURGERY
- CARPAL TUNNEL
- CESAREAN SECTION
- JOINT REPLACEMENT (Location) \_\_\_\_\_
- OTHER SURGERY \_\_\_\_\_
- D & C
- GALLBLADDER SURGERY
- HEART BYPASS
- HEART VALVE REPLACEMENT
- HERNIA REPAIR
- HYSTERECTOMY
- KIDNEY SURGERY
- NECK SURGERY
- PACEMAKER
- PROSTATE SURGERY
- SKIN CANCER
- TONSILLECTOMY

**REVIEW OF SYSTEMS:** (Check all that apply)

- |  |                        |  |                                   |  |             |
|--|------------------------|--|-----------------------------------|--|-------------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | FEVER                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | ARTHRITIS                         | <input type="checkbox"/> Yes <input type="checkbox"/> No | MIGRAINES   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | FATIGUE                | <input type="checkbox"/> Yes <input type="checkbox"/> No | ANKLE SWELLING                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | INSOMNIA    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | DOUBLE VISION/BLURRING | <input type="checkbox"/> Yes <input type="checkbox"/> No | ABDOMINAL PAIN                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | SINUSITIS   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | LOSS OF HEARING        | <input type="checkbox"/> Yes <input type="checkbox"/> No | CHEST PAIN                        | <input type="checkbox"/> Yes <input type="checkbox"/> No | WEIGHT LOSS |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | RINGING IN THE EARS    | <input type="checkbox"/> Yes <input type="checkbox"/> No | SWOLLEN GLANDS                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | PALPATIONS  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | SHORTNESS OF BREATH    | <input type="checkbox"/> Yes <input type="checkbox"/> No | SKIN CHANGES / RASHES             |  |             |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | VERTIGO / IMBALANCE    | <input type="checkbox"/> Yes <input type="checkbox"/> No | CHANGE IN BOWEL OR BLADDER HABITS |  |             |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | VARICOSE VEINS         | <input type="checkbox"/> Yes <input type="checkbox"/> No | FREQUENT BLADDER INFECTIONS       |  |             |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | NIGHT LEG CRAMPS       | <input type="checkbox"/> Yes <input type="checkbox"/> No | ANXIETY REQUIRING MEDICATION      |  |             |

**FAMILY HISTORY** (Check if applies)

- FATHER'S HEALTH  GOOD  FAIR  POOR  DECEASED (cause) \_\_\_\_\_ AGE: \_\_\_\_\_
- MOTHER'S HEALTH  GOOD  FAIR  POOR  DECEASED (cause) \_\_\_\_\_ AGE: \_\_\_\_\_
- ANY FAMILY MEMBER WITH CURRENT RELATED ORTHOPAEDIC PROBLEM (Relationship to patient) \_\_\_\_\_

**SOCIAL HISTORY**

OCCUPATION \_\_\_\_\_  ACTIVE  RETIRED

ALCOHOL USE?  NONE  SOCIAL  FREQUENT

SMOKING HISTORY:  NON-SMOKER  PREVIOUS SMOKER (How long ago did you quit?) \_\_\_\_\_  
 CURRENT SMOKER AMOUNT?  1/4 PACK/DAY  1/2 PACK/DAY  \_\_\_\_\_ PACKS/DAY

WHO IS YOUR LOCAL MEDICAL DOCTOR? \_\_\_\_\_

**WHO RECOMMENDED YOU TO THIS OFFICE?** (Please give name of person who referred you to this office)

- DOCTOR \_\_\_\_\_  FAMILY \_\_\_\_\_
- FRIEND \_\_\_\_\_  OTHER \_\_\_\_\_

PATIENT SIGNATURE \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**DO NOT FILL IN BELOW THIS LINE - FOR PHYSICIAN USE**

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ PULSE \_\_\_\_\_

PHYSICIAN SIGNATURE \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_