SIERRA PACIFIC ORTHOPAEDIC & SPINE CENTER
MEDICAL GROUP, INC.

# PATIENT HISTORY FORM

Name: _____ Today's Date: _____
Age: ____ Occupation: _____ ❑Right-handed ❑Left-handed
Height:_____ Weight:_____

## History of Current Problem

What body part is involved?_____ Left/Right/Both(circle)

When did your problem start?_____

How did the injury/problem start? _____

_____

Where did the problem occur? _____

What treatment have you already had? _____

Were you injured at work? ❑ Yes ❑ No
Are you currently working? ❑ Regular work ❑ Modified work ❑ Not working

## Past Medical History Do you have a history of the following problems?

| | | |
|---|---|---|
| ❑ High blood pressure | ❑ Asthma | ❑ Emphysema or COPD |
| ❑ Heart Arrhythmia | ❑ Diabetes | ❑ Ulcers |
| ❑ Coronary artery disease or heart attacks | ❑ Liver disorder | ❑ TB |
| | ❑ Rheumatoid arthritis | ❑ Arthritis |
| ❑ Cancer (type):_____ | ❑ Deep vein thrombus | ❑ Polio |
| ❑ Seizures/Epilepsy | ❑ Bleeding disorder | ❑ Problems with anesthesia |
| ❑ Alcohol use | ❑ Tobacco use | ❑ Recreational drugs |
| ❑ Sleep Apnea | ❑ Claustrophobia | ❑ Other |

| Surgeries/Hospitalizations | Year | Complications |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## Medications Please list all medications that you currently are taking.

| Medication(s) | Dose | Reason for Medication |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

*Over*

*Revised 8/2/2004*

Name: _____ Today's Date: _____

**ALLERGIES:** **Latex** ❑ **Yes** ❑ **No**
**Iodine** ❑ **Yes** ❑ **No**
**Other** _____
_____
_____

❑ **None Known**

## Social History

| | | | | |
|---|---|---|---|---|
| Marital status | ❑ Single | ❑ Married | ❑ Divorced | ❑ Widowed |
| Do you exercise? | ❑ Daily | ❑ Weekly | ❑ Monthly | ❑ Never |
| Smoke | ❑ Yes | ❑ Quit | ❑ Never | How much? _____ |
| Alcohol | ❑ Yes | ❑ Quit | ❑ Never | How often? _____ |

Do you have a Durable Power of Attorney? ❑ Yes ❑ No

## Family History

| Member | Alive | Deceased | Age | Health status or cause of death |
|---|---|---|---|---|
| Father | ❑ | ❑ | ____ | _____ |
| Mother | ❑ | ❑ | ____ | _____ |
| Sister/brother | ❑ | ❑ | ____ | _____ |
| Sister/brother | ❑ | ❑ | ____ | _____ |
| Sister/brother | ❑ | ❑ | ____ | _____ |
| Children | ❑ | ❑ | ____ | _____ |
| Children | ❑ | ❑ | ____ | _____ |
| Children | ❑ | ❑ | | |

## Review of Systems

Are you currently having problems with any of the following:

| | Yes | No | Describe all Yes responses |
|---|---|---|---|
| Eyes | ❑ | ❑ | _____ |
| Ears, nose, throat | ❑ | ❑ | _____ |
| Heart | ❑ | ❑ | _____ |
| Lungs, breathing | ❑ | ❑ | _____ |
| Digestion/bowels | ❑ | ❑ | _____ |
| Bladder | ❑ | ❑ | _____ |
| Bleeding problems | ❑ | ❑ | _____ |
| Balance problems | ❑ | ❑ | _____ |
| Blackout/fainting | ❑ | ❑ | _____ |
| Numbness/tingling | ❑ | ❑ | _____ |
| Psychological problems | ❑ | ❑ | _____ |
| Weight Loss | ❑ | ❑ | _____ |
| Fevers | ❑ | ❑ | _____ |
| Osteoporosis | ❑ | ❑ | _____ |

Have you ever had your bone density tested? ❑ Yes ❑ No When_____ Where_____

**Patient signature:** _____ **Date:** _____

**Physician signature:** _____ **Date:** _____

*Revised 8/2/2004*