Sports and Spine Orthopaedics

Clinical Patient Information and Medical History

(Please type or print legibly)

Name: _____ Date:_____

Age:_____ Date of birth:_____ Sex: ☐ Male ☐ Female

Wt _____ HT_____ Hand dominance: ☐ Right ☐ Left

Referring physician:_____ Primary care physician (if any):_____

Chief complaint: (what are you here for today?) _____ Date of injury: _____

Where did the injury occur? ☐ Work ☐ Other Have you been treated for this problem by another doctor? ☐ Yes ☐ No

Prior treatments: ☐ None ☐ Bracing ☐ Pain medications ☐ Injections ☐ Chiropractic ☐ Surgery ☐ Other

Medical history: (please check previous or current conditions)

☐ None	☐ Anemia	☐ COPD/lung disease	☐ High blood pressure	☐ Prostate
	☐ Arthritis	☐ Depression	☐ High cholesterol	☐ Stomach ulcers/reflux
	☐ Asthma	☐ Diabetes	☐ HIV/AIDS	☐ Seizures
	☐ Blood clots/DVT	☐ Heart disease	☐ Liver disease	☐ Thyroid disease
	☐ Cancer	☐ Hepatitis	☐ Osteoporosis	☐ Vascular disease

☐ Other (please list) _____

Previous surgeries: (list type of surgery, right or left side, year, where, by whom, etc)

1. _____
2. _____
3. _____

Current medications: (list medication and dosage, if known)

1. _____ 4._____
2. _____ 5. _____
3. _____ 6. _____

Known allergies: (list allergy and reaction) _____

Social history: Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Occupation:_____ Hobbies: _____

Do you smoke? ☐ Yes ☐ No Packs/day? _____ Do you drink alcohol? ☐ No ☐ Rare ☐ Social ☐ Daily

Family history: (check all that apply) ☐ Heart disease ☐ Diabetes ☐ Bleeding disorders ☐ Other_____

Review of systems: (Check any positives)				
	General	☐ Fatigue	☐ Weight loss /gain	☐ Fever /chills
	Heart	☐ Shortness of breath	☐ Chest pain	☐ Palpitations
	Lungs	☐ Productive cough	☐ Wheezing	☐ Coughing up blood
	GI	☐ Heartburn	☐ Abdominal pain	☐ Nausea/vomiting
	Urinary/reproductive	☐ Blood in urine	☐ Incontinence	☐ Sexual dysfunction
	Skin	☐ Skin lesions	☐ Psoriasis	☐ Chronic rash
	Neurological	☐ Seizures	☐ Migraines	☐ History of stroke
	Musculoskeletal	☐ Joint pain	☐ Joint swelling	☐ Muscle pain
	Psychiatric	☐ Depression	☐ Anxiety	☐ Mood swings
	Hematologic	☐ Easy bruising	☐ Easy bleeding	

Patient Signature Date