PLEASE FILL IN THE BUBBLES COMPLETELY.

ORTHOPEDIC ASSOCIATES of Port Huron, P.C.

Patient Health History

Patient Name: _____ [redacted]

Sex: ○ M ○ F **Height:** _____ **Weight:** _____ **Employer:** _____

[redacted] [redacted]

[redacted] **Primary Care Doctor:** _____

Part of the body being seen for today: ○ R ○ L _____

Past surgeries: ○ **None** _____

_____

Current Medications: ○ **None** _____

Allergies to Medicines: ○ **None** _____

Latex allergy? ○ Yes ○ No **Metal allergy?** ○ Yes ○ No

Medical Conditions: ○ **None**

Chest pain	○ Yes	○ No	Nose/throat problems	○ Yes	○ No	Dizziness	○ Yes	○ No
Heart disease	○ Yes	○ No	Blurred vision	○ Yes	○ No	Epilepsy	○ Yes	○ No
High blood pressure	○ Yes	○ No	Glasses/Contacts	○ Yes	○ No	Headaches	○ Yes	○ No
High cholesterol	○ Yes	○ No	Glaucoma	○ Yes	○ No	Depression	○ Yes	○ No
Palpitations	○ Yes	○ No	Indigestion	○ Yes	○ No	Nervousness	○ Yes	○ No
Fever	○ Yes	○ No	Nausea	○ Yes	○ No	Cough	○ Yes	○ No
Weight gain	○ Yes	○ No	Stomach ulcers	○ Yes	○ No	Lung disease	○ Yes	○ No
Weight loss	○ Yes	○ No	Kidney disease	○ Yes	○ No	Shortness of breath	○ Yes	○ No
Diabetes	○ Yes	○ No	Blood clots	○ Yes	○ No	HIV / AIDS	○ Yes	○ No
Low thyroid	○ Yes	○ No	Hepatitis	○ Yes	○ No	Unsteady gait	○ Yes	○ No
Earaches	○ Yes	○ No	Rash	○ Yes	○ No	Cancer	○ Yes	○ No
Hearing loss	○ Yes	○ No	Skin disorders	○ Yes	○ No	If yes, type of cancer: _____		

Other System Problems: ○ **None** _____

_____

Have your father, mother, or siblings had any of the following disorders?

○ None ○ Diabetes ○ Anesthesia Problems ○ High Blood Pressure ○ Bleeding Problems

Smoker: ○ Current every day smoker ○ Current some day smoker ○ Former smoker ○ Never smoker

Alcohol: ○ Frequent ○ Occasional ○ Never **Are you pregnant?** ○ Yes ○ No

Pharmacy Name/Location: _____

Description of Injury: _____

Date of Injury: ____/____/____

Was the Injury: Work Related? ○ No ○ Yes **From an Auto Accident?** ○ No ○ Yes

Hand Dominance: ○ Right ○ Left ○ Ambidextrous

On a scale of 1-10 (10 being the worst), how severe is your pain? (only choose one)

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

What are the symptoms that you experience?

○ Pain ○ Stiffness ○ Swelling ○ Bruising ○ Numbness ○ Tingling ○ Weakness
○ Locking/Catching ○ Giving way ○ Clicking ○ Bowel or bladder dysfunction

Other: _____

What is the quality of your pain?

○ Sharp ○ Dull ○ Stabbing ○ Throbbing ○ Aching ○ Burning

How often do you have your pain?

○ Constantly ○ Intermittently (comes and goes)

What activities make your symptoms worse?

○ Standing ○ Walking ○ Running ○ Lifting ○ Twisting ○ Bending ○ Stairs
○ Exercise ○ Squatting ○ Kneeling ○ Sitting ○ Coughing ○ Sneezing ○ Lying in bed

Other: _____

Have you been off work / school due to your symptoms?

○ No ○ Yes, If yes, what was your first day off work / school? ____/____/_____ (date)
○ N/A, I do not work outside my home

What medication have you taken for your symptoms?

○ Aleve ○ Celebrex ○ Mobic ○ Motrin (Ibuprofen) ○ Naprosyn ○ Medrol Dosepak ○ Prednisone
○ Norco (Hydrocodone) ○ Ultram (Tramadol) ○ Tylenol #3

Other: _____

How long have you taken this medication?

_____

What treatment have you had for these symptoms? **(please fill in all that apply)**

○ Brace/Splint ○ Cane ○ Walker ○ Orthotics ○ Physical Therapy
○ Chiropractic manipulation ○ Cortisone injection ○ Epidural Steroid Injection ○ Surgery

Other: _____

_____ ____/____/_____

Patient Signature Date form completed