PROVIDENCE
Medical Group

Providence Orthopedics
Patient History Worksheet

Name: ______________________________ Referring Doctor: ______________________________

PRESENT HISTORY

Area of body to be examined: ______________________________ Which Side? ❑ Left ❑ Right

Date of injury or onset of problem (month / day / year) ______________________________

Briefly describe your problem today: ______________________________

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PAST HISTORY

List all other medical problems for which you see your Dr. regularly: ______________________________

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List all previous serious injuries (fractures, sprains, back injuries, etc.):

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List all previous surgeries (with dates): ______________________________

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List all medications and dosages (including any pain medications and/or aspirin): ______________________________

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List all medications to which you are allergic: ______________________________

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List all other allergies (food, dust, metals): ______________________________

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PERSONAL INFORMATION

Habits:

Consumption of alcoholic beverages: ❑ Never ❑ Occasionally ❑ Daily Specify Type: ______________________________

Use of tobacco products: ❑ Yes ❑ No What type: ❑ Cigarettes ❑ Cigars ❑ Chew How Often: ______________________________

Marriage Status: ❑ Single ❑ Married (Number of Marriages_____) ❑ Divorced ❑ Widow(er)

Dependents: Children: ______________________________

Ages: ______________________________

Occupation: ______________________________

Major sport or excercise activity: ______________________________

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(over)

Please check off those conditions below which apply to you now or within the recent past.
Be careful to read them all. If you are not sure whether a symptom applies to you, check it anyway.
Your physician will expand the point when he goes over this form with you.

My general heath is: ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Have you had?	YES	NO	Have you had?	YES	NO
Frequent nose bleeds			Hepatitis		
Frequent sinus infection			Frequent desire to urinate		
Pneumonia (when)			Pain or burning on urination		
Chronic morning cough			Blood red urine		
Cough with phlegm during day			A kidney stone		
Asthma as an adult			Bladder infectios		
Shortness of breath with work, that is unusual for your age			Kidney infections		
Tuberculosis			Up during the night to urinate		
Chest pain or pressure from exertion that goes away if you stop			Trouble starting urine stream		
Rheumatic fever			Loss of urine with sneezing or straining		
Heart murmur			Sugar in the urine (diabetes) after trouble starting urine stream		
Heart attack			Excessive bleeding after operation		
Palpitations of the heart			Difficulty making decisions		
High blood pressure			Difficulty concentrating		
Shortness of breath when lying down			Excessive irritability		
Shortness of breath when walking up stairs that is unusual for you			Excessive nervousness		
Phlebitis			A feeling or need to see a psychiatrist		
Varicose veins			Have you seen a psychiatrist in the past		
Blood vessel surgery or injury			Are you epileptic		
Heart burn			Convulsions or seizures		
Ulcer			Yellow jaundice		
Was your ulcer diagnosed by x-ray			Last menstrual period (if applicable)		
Stomach or chest pain relieved by food or milk			Are you currently pregnant		
Blood in vomit or stool			Easy infection of teeth		
Tarry black & foul smelling stool			Bone infection		

Is there a history of the following in your immediate family?

Diabetes Y / N Heart Disease Y / N Bleeding problems Y / N Trouble with anesthesia Y / N
(less than 60 years old)

Physician's Signature____ Date____________________