HENDRICKS ORTHOPEDICS
& SPORTS MEDICINE

Patient History Form

Name: ____ Birth Date:____/_____/_____

Please describe reason for coming______________________________ Body Part ___________ O Right O Left O Both

O New Injury O Chronic Symptoms When/How did symptoms begin____

Injury Resulting from: O Sports O Accident O Work Related O Involving Litigation

Allergy Information

Any drug allergies O Yes O No Allergic to Latex OYes O No
If so, please list the drugs and type of reaction (example: rash, nausea, etc.) PLEASE BE SPECIFIC

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Medication Information

List any current medications that you are taking at this time. Please include over the counter medications, vitamins, herbs, etc. (If you have a list, we can copy it)

Name of Medication	Dose (Include strength and number of pills per day)
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

Past Surgical /Hospitalization History

Previous Surgery/Hospitalization	Year
1.	
2.	
3.	
4.	
5.	

Family Medical History (Please check if a family member has a history of the condition and list the relation of family member with condition)

- o Alcohol/Drug Abuse ___________________________
- o Arthritis (RA, OA, Gout)_________________________
- o Bleeding Disorder___________________________
- o Cancer(Type:)________________
- o Diabetes_____________________________________
- o Glaucoma___________________________________
- o Heart Disease ______________________________
- o High Blood Pressure _________________________
- o Death before 50 ____________________________
- o Marfan Syndrome___________________________
- o Mental Illness_______________________________
- o Stroke_____________________________________

Please Turn over and complete the back of the form

Social History

Married/Single Do you live alone? ○ Yes ○ No If no, who do you live with?______________________________________

Do you exercise regularly ○ Yes ○ No Please describe activities____

Occupation__________________________ Number of Years______ Job Duties___________________________________

Dominant Hand: ○ Right ○ Left Do you use a seatbelt on a regular basis ○ Yes ○ No

Tobacco Use? ○ Yes ○ No Type:_________________ Amount per day___________ Number of years used_______

Alcohol Consumption? ○ Yes ○ No Number of drinks/week: ______________ History of Alcoholism ○ Yes ○ No

Recreational/ Drug Use? ○ Yes ○ No Type/Amount/How often:____

Medical History/Review of Systems

Please check if you have a history of the following:

Psychological

- ○ Anxiety Disorder
- ○ Depression
- ○ Other

Urology

- ○ History of Kidney Disease
- ○ Urinary Infection
- ○ Hematuria (Blood in Urine)
- ○ Jaundice

Infectious Disease

- ○ Hepatitis
- ○ Immune Disorder
- ○ Mononucleosis

Dermatology

- ○ Skin Problems Type:

Female Reproductive

- ○ Currently Pregnant

Date of first menstrual cycle:___________

Date of last menstrual cycle:____________

Longest time between periods:_______

Cardiovascular

- ○ High blood Pressure/hypertension
- ○ Heart attack/ Myocardial Infarction
- ○ Ankle Swelling
- ○ Chest Pain/Angina
- ○ Palpitations
- ○ Shortness of Breath
- ○ Heart Murmur

Constitutional

- ○ History of Cancer
- ○ Fatigue
- ○ Fever
- ○ Weight Change
- ○ Anorexia or Bulimia
- ○ Hernia

Endocrinology

- ○ Thyroid Problems
- ○ Diabetes

ENT

- ○ Dental Infection
- ○ Eye Trouble
- ○ Hearing Loss

Gastroenterology

- ○ Ulcers

Hematology

- ○ Blood Clots
- ○ On Blood Thinners
- ○ Bruise/Bleed Easily
- ○ Anemia

Musculoskeletal

- ○ Muscle Weakness
- ○ Gout
- ○ Infection in extremities
- ○ Arthritis Type:
- ○ Osteoporosis
- ○ Previous Bone Density Test
- ○ Joint Pain
- ○ Joint Swelling
- ○ Previous Fracture

Neurological

- ○ Muscle Spasms
- ○ History of Stroke
- ○ Dizziness/Fainting
- ○ Headache
- ○ Epilepsy
- ○ Tingling/Numbness
- ○ Concussion

Respiratory

- ○ TB Exposure
- ○ History of asthma/lung disease
- ○ Chronic Cough