HC HIGHLAND CLINIC

DATE: _______________
MD you are seeing today
____

HIGHLAND CENTER FOR
ORTHOPAEDICS & SPORTS MEDICINE

PCP/REFERRING MD
____

<u>PATIENT HISTORY FORM</u>

Name:____DOB:_________________________Age:_________

Reason for Visit:____

Past Medical History:
Do you have?

- ☐ None
- ☐ Heart Disease
- ☐ Lung Disease
- ☐ Diabete
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Thyroid Disease
- ☐ Other______________________________
- ☐ Cancer
- ☐ Depression
- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ Asthma
- ☐ Gout
- ☐ Mitral Valve Prolapse
- ☐ High Blood Pressure

Ortho Surgery

☐Bone or Joint
Type:______________
____
____
____
____

Past Surgical History:
Have you had?

- ☐ Thyroid
- ☐ Appendectomy
- ☐ Hysterectomy
- ☐ Wisdom Teeth
- ☐ Gallbladder
- ☐ Tonsillectomy
- ☐ Other________________
- ☐ None

***Allergies: ☐NONE or list each allergy____

Medications: *Drug Name Dose/Strength How you take it (for example, once a day, twice a day, etc)* ☐ None

____ ____
____ ____
____ ____
____ ____
____ ____
____ ____
____ ____

Family History:

- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Lung Disease
- ☐ Diabetes
- ☐ Osteoporosis
- ☐ Other________________
- ☐ Cancer
- ☐ Depression
- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ Fibromyalgia
- ☐ None

Social History:

Occupation:__________________________
Dominant Hand: R L
Tobacco Use ☐ current ☐ former ☐ never
Type__________________ ________amt/day
☐ Alcohol Use Yes No
Height_________ Weight_________

Review of Systems: ***Do you have?***

- ☐ Fatigue
- ☐ Chills
- ☐ Fever
- ☐ Weight Gain
- ☐ Weight loss
- ☐ Chest Pain
- ☐ Irregular Heartbeat
- ☐ Skin Rash
- ☐ Skin Lesion
- ☐ Chronic Headache
- ☐ Constipation
- ☐ Reflux
- ☐ Blood in stool
- ☐ Diarrhea
- ☐ Nausea/Vomiting
- ☐ Seizures
- ☐ Asthma
- ☐ Depression
- ☐ Bruising
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Painful Urination
- ☐ Frequent Urination