Patient Medical History

Paris Orthopedics and Sports Medicine

Please Answer ALL Questions COMPLETELY!

Office Use ONLY

Blood Pressure: _____

Temperature: _____

Heart Rate: _____

Date: _____

Patient Name: _____

DOB: _____ **Age:** ____ **Sex:** ____ **Height:** _____ **Weight:** _____ **R or L Handed:** ___ **Marital Status:** _____

Where do you hurt: _____ **RIGHT or LEFT Side:** _____

How long have you hurt? _____ **Any Fever?** _____

How did you hurt yourself? _____

What have you taken for pain? _____

Did you go to an E.R.? *YES or NO* **Where?** _____ **When?** _____

Were X-RAYS Taken? *YES or NO* **An MRI?** *YES or NO* **Do you have the Disk or Reports with you?** *YES or NO*

Have you or a family member ever had any of the following conditions? *(Circle ALL that apply: U=You M=Mother F=Father S=Sibling)*

IF NONE CHECK HERE: ☐

Diabetes..... U M F S	*High Blood Pressure*... U M F S	*High Cholesterol*..... U M F S	*Infections*..... U M F S	Stroke..... U M F S
Heart Problems..... U M F S	*Bleeding Problems*..... U M F S	*Arthritis*..... U M F S	*Seizures*..... U M F S	Osteoporosis..... U M F S
Kidney Problems.... U M F S	*Thyroid Issue*..... U M F S	*Asthma*..... U M F S	*Depression*..... U M F S	Prior Blood Clots..... U M F S
Cancer..... U M F S	*Stomach Problems*..... U M F S	*Respiratory Problems*... U M F S	*Alcohol Addiction*... U M F S	Other _____ U M F S

Are you Pregnant? *YES or NO* **If YES, how far along?** _____

Do you have a Pace Maker? *YES or NO* **Heart Stents?** YES or NO

Date of Last DEXA (bone density)_____ **Have you ever had a fracture?** YES or NO

Please list ALL Surgeries that you have had: (Use back of sheet if necessary)

1 _____ **L or R** **Year:** _____ **Complications:** _____

2 _____ **L or R** **Year:** _____ **Complications:** _____

3 _____ **L or R** **Year:** _____ **Complications:** _____

4 _____ **L or R** **Year:** _____ **Complications:** _____

Please List ALL Medications that you take? (Use back of sheet if necessary)

1. _____ **Dosage:** _____ 5. _____ **Dosage:** _____

2. _____ **Dosage:** _____ 6. _____ **Dosage:** _____

3. _____ **Dosage:** _____ 7. _____ **Dosage:** _____

4. _____ **Dosage:** _____ 8. _____ **Dosage:** _____

What Medication/Other Allergies do you have?

1. _____ 2. _____ 3. _____

Do you Smoke? *Currently Never Former* **Packs per day?** _____ **Year Started?** _____ **Year Stopped?** _____

Do you use Smokeless Tobacco? *Currently Never Former* **Year Started?** _____ **Year Stopped?** _____

Do you drink Alcohol? *YES or NO* **Type?** _____ **How Frequently?** _____

Describe your Job: _____

Who is your Primary Care Physician? _____

Have you ever been treated by any Physician at POC, if so who? _____

What Pharmacy Do You Prefer? _____ **City:** _____

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