# New Patient History

Lakeshore Orthopaedics
Holy Family Memorial
*Sponsored by the Franciscan Sisters of Christian Charity*

Patient Name: _____ Birth Date: _____ Sex: ☐ M ☐ F

Today's Date: _____ Date of Injury: _____ ☐ Right-handed ☐ Left-handed

Occupation: _____ Primary Care Physician: _____ Phone #: _____

Is this work related? ☐ Yes ☐ No

Were you sent to our office by a physician? ☐ Yes ☐ No If so, please provide: Was it reported? ☐ Yes ☐ No

Requesting Physician's Name: _____ Phone: _____

Physician Address: _____ City/ State: _____

**HISTORY OF PRESENT ILLNESS:** Age: _____ Problem with which extremity? ☐ Right ☐ Left

CC/ Why are you here today?

Location: _____
*Where is the pain/ problem? Does it travel to other areas?*

Quality: _____
*Describe the pain. Is the pain dull, throbbing, or sharp?*

Severity: _____
*How severe is the pain on a scale of 0-10, with 10 being the most severe?*

Duration: _____
*How long have you had this pain/ problem? When did it start?*

Timing: _____
*When does the pain/ problem occur (after exercise, at night, etc.)? Is it intermittent, or constant? How frequent is the pain/ problem?*

Context: _____
*What caused the pain/ problem? Was there a specific injury?*

Associated signs/ symptoms: _____
*What other associated problems are you having? (Numbness, swelling, cracking, popping, grinding, locking, etc.)*

Modifying factors: _____
*What makes the pain/ problem better (rest, ice, medications)? What makes the pain/ problem worse (work, athletics, specific activities)?*

Have you seen any other physicians regarding this condition, prior to coming to our office? ☐ Yes ☐ No

| Doctor | When | Tests | Results | Treatment |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

**PAST HISTORY OF PRESENT ILLNESS:**

Have you previously experienced any injury or symptoms regarding this body part? ☐ Yes ☐ No

If so, please provide details: _____

Please list any hobbies/ sports you enjoy: _____

Which of the above activities are you unable to perform due to your pain? _____

**PAST MEDICAL HISTORY:** Have you ever had any of the following? Please check all pertinent boxes:

☐ Cancer: What Type? _____

| | | | | |
|---|---|---|---|---|
| ☐ Chest Pain/Angina | ☐ Pacemaker | ☐ High Cholesterol | ☐ Bleeding Disorder | ☐ Migraine Headaches |
| ☐ Atrial Fibrillation | ☐ Rheumatic Fever | ☐ Overactive Thyroid | ☐ Blood Transfusions | ☐ Stroke |
| ☐ Heart/Cardiac Artery Dis. | ☐ Asthma | ☐ Underactive Thyroid | ☐ Chicken Pox | ☐ Glaucoma |
| ☐ Congestive Heart Failure | ☐ Bronchitis | ☐ Hemorrhoids | ☐ HIV or AIDS | ☐ Other: (please list) |
| ☐ Blood Clot (DVT) | ☐ COPD (chronic lung dis.) | ☐ Hepatitis | ☐ MRSA | |
| ☐ Heart Attack | ☐ Emphysema | ☐ Ulcers | ☐ Measles | |
| ☐ Heart Murmur | ☐ Pneumonia | ☐ Bladder Infections | ☐ Tuberculosis | |
| ☐ High Blood Pressure | ☐ Pulmonary Embolus | ☐ Kidney Infections | ☐ Arthritis | |
| ☐ Low Blood Pressure | ☐ Sleep Apnea | ☐ Venereal Disease | ☐ Back Trouble | |
| ☐ Mitral Valve Prolapse | ☐ Diabetes | ☐ Anemia | ☐ Epilepsy/Seizure | |

PLEASE COMPLETE OTHER SIDE

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**Medications: Include non-prescription & supplements**

| Drug Name | Dosage | Frequency |
|---|---|---|
| | | |
| | | |
| | | |

**Allergies:**

| Medication | Reaction |
|---|---|
| | |
| | |

**Tape Allergy:** ☐ Yes ☐ No **Latex Allergy:** ☐ Yes ☐ No

**Past Surgical/ Hospitalization History:**

| Date | Surgery/ Illness | Doctor | Hospital, City, State |
|---|---|---|---|
| | | | |
| | | | |

**Patient Social History:**

| Marital Status | Use of Alcohol | Use of Tobacco | Living Situation |
|---|---|---|---|
| ☐ Single | ☐ Never | ☐ Never | ☐ With Family |
| ☐ Married | ☐ Rarely | ☐ Previously, but quit | ☐ With Friends |
| ☐ Divorced | ☐ Moderately | ☐ Currently | ☐ Alone |
| ☐ Widowed | ☐ Daily | | ☐ Other |

**Family Medical History:**

| | Age | Conditions or Diseases | If Deceased, Cause of Death |
|---|---|---|---|
| Father | | | |
| Mother | | | |
| Siblings | | | |
| | | | |

**Review of Systems: Please indicate any personal history below.** **(Please circle all that apply)**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Musculoskeletal** | | | **Genitourinary** | | | **Hematologic/ Lymphatic** | | |
| Joint pain | No | Yes | Frequent urination | No | Yes | Enlarged glands | No | Yes |
| Joint stiffness or swelling | No | Yes | Burning or painful urination | No | Yes | Bleeding or bruising tendency | No | Yes |
| Muscle pain or cramps | No | Yes | Blood in urine | No | Yes | | | |
| Back pain | No | Yes | Incontinence or dribbling | No | Yes | **Psychiatric** | | |
| | | | | | | Memory loss or confusion | No | Yes |
| **Constitutional Symptoms** | | | **Integumentary (skin, breast)** | | | Anxiety | No | Yes |
| Recent weight change | No | Yes | Rash or itching | No | Yes | Depression | No | Yes |
| Fever | No | Yes | Changes in skin color | No | Yes | Suicidal thoughts | No | Yes |
| Fatigue | No | Yes | Varicose veins | No | Yes | | | |
| Headaches | No | Yes | | | | **Gastrointestinal** | | |
| | | | **Neurological** | | | Nausea or vomiting | No | Yes |
| **Ears/ Nose/ Mouth/ Throat** | | | Light headed or dizzy | No | Yes | Frequent diarrhea | No | Yes |
| Hearing loss or ringing | No | Yes | Numbness or tingling sensations | No | Yes | Constipation | No | Yes |
| Nose bleeds | No | Yes | Tremors | No | Yes | Rectal bleeding, blood in stool | No | Yes |
| Bleeding gums | No | Yes | | | | Abdominal pain | No | Yes |
| Sore throat or voice change | No | Yes | **Endocrine** | | | | | |
| | | | Excessive thirst | No | Yes | **Respiratory** | | |
| **Cardiovascular** | | | Heat or cold intolerance | No | Yes | Chronic or frequent coughs | No | Yes |
| Chest pain | No | Yes | Skin becoming drier | No | Yes | Spitting up blood | No | Yes |
| Palpitation | No | Yes | | | | Shortness of breath | No | Yes |
| Exercise intolerance | No | Yes | | | | Wheezing | No | Yes |

*Signature of Patient or Parent of Minor* *Date*

*Signature of Physician* *Date*

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