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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