

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 #: _____

Were you sent to our office by a physician? Yes No

If so, please provide: Is this work related? Yes No 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: _____ Quality: _____
Where is the pain/ problem? Does it travel to other areas? *Describe the pain. Is the pain dull, throbbing, or sharp?*

Severity: _____ Duration: _____
How severe is the pain on a scale of 0-10, with 10 being the most severe? *How long have you had this pain/ problem? When did it start?*

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

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?

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

Musculoskeletal

Joint pain No Yes
 Joint stiffness or swelling No Yes
 Muscle pain or cramps No Yes
 Back pain No Yes

Genitourinary

Frequent urination No Yes
 Burning or painful urination No Yes
 Blood in urine No Yes
 Incontinence or dribbling No Yes

Psychiatric

Memory loss or confusion No Yes
 Anxiety No Yes
 Depression No Yes
 Suicidal thoughts No Yes

Constitutional Symptoms

Recent weight change No Yes
 Fever No Yes
 Fatigue No Yes
 Headaches No Yes

Integumentary (skin, breast)

Rash or itching No Yes
 Changes in skin color No Yes
 Varicose veins No Yes

Gastrointestinal

Nausea or vomiting No Yes
 Frequent diarrhea No Yes
 Constipation No Yes
 Rectal bleeding, blood in stool No Yes

Neurological

Light headed or dizzy No Yes

Ears/ Nose/ Mouth/ Throat

Hearing loss or ringing No Yes
 Nose bleeds No Yes
 Bleeding gums No Yes
 Sore throat or voice change No Yes

Endocrine

Excessive thirst No Yes
 Heat or cold intolerance No Yes

Cardiovascular

Chest pain No Yes
 Palpitations No Yes
 Exercise intolerance No Yes

Skin becoming drier No Yes

Hematologic/ Lymphatic

Enlarged glands No Yes
 Bleeding or bruising tendency No Yes

Respiratory

Chronic or frequent cough No Yes
 Spitting up blood No Yes
 Shortness of breath No Yes
 Wheezing No Yes

Allergic/ Immunologic

List food/ environmental allergies:

Signature of Patient or Parent of Minor

Date