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: _____
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)?

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?

Print Shop Reorder #15855-19
Revised January 2015

Patient History

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

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

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

_____ _____

Signature of Patient or Parent of Minor *Date*

Print Shop Reorder #15855-19
Revised January 2015