HOUSTON Methodist
ORTHOPEDICS & SPORTS MEDICINE

Patient History Form - Orthopedics

PLEASE PRINT

Last Name:	First name:	Date:
Email Address:	Pharmacy Phone:	
Pharmacy Name:	Pharmacy Address:	

Age: _____ Date of Birth: Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Partnered ☐ Separated ☐ Widowed

Occupation / Company:

Work status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Disabled ☐ Volunteer ☐ Not Currently Employed ☐ Student

Students only:	School:	Grade:

Who is your Primary Care Physician? _____ Last visit to him/her? _____

How did you hear about us? ☐ Internet ☐ Ad ☐ Hospital ☐ Word of Mouth ☐ School ☐ Other_____

WHERE DID THE INJURY OCCUR: ☐ HOME ☐ AUTO ☐ WORK ☐ SCHOOL ☐ OTHER Date:_____

BRIEF REASON FOR VISIT: **Right ☐ Left ☐**

MEDICATIONS: *(If you need more space, please use the separate medication sheet)*

☐ **None** **Are you on a blood thinner? Yes ☐ No ☐**

Medication/Dosage	Medication/Dosage

ALLERGIES to medications/medical equipment

☐ **No Allergies Known**

Medications You Are Allergic To:	Type of reaction

Do you have an allergy to any of the following:	Yes	No	Type of reaction
Latex			
Adhesives or tape			
Iodine or IV contrast			

Patient Name: _____

MEDICAL HISTORY

Have you ever had any of the following medical conditions? PLEASE CHECK

☐ **No Medical Conditions Known**

Anemia	Blood Clot/PE	Diabetes	Hypertension	Stroke
Arthritis	Cancer/ type:	GERD	Kidney Disease	Thyroid Disease
Asthma	COPD	Hepatitis	Heart Attack/MI	TB
Bleeding Disorder	Dementia	HIV/AIDS	Osteoporosis	Ulcers/GI Bleed

Other – Please explain: _____

RECENT SURGICAL/HOSPITALIZATION HISTORY:

☐ **No Surgical/Hospital History**

SURGERIES

	Yes	No	Year		Yes	No	Year
Abdominal Surgery				Orthopedic Surgery			
Brain Surgery				Spine Surgery			
CABG				Stent			
Heart Surgery				Wt. Loss Surgery			
Joint Replacement				Other			

FAMILY HISTORY

Is your family member: **Living (L)** or **Deceased (D)**?	**Mother** L ☐ D ☐	**Father** L ☐ D ☐	**Siblings** L ☐ D ☐
If deceased, what was the cause?			

Do any of the following diseases run in your family? If so, please check the diseases that do.

	Mother	Father	Siblings
Kidney Disease			
Heart Disease / Heart Attack			
Cancer / Type?			
Stroke			
Bleeding Disorders			
Diabetes			

SOCIAL HISTORY/ HABITS

PLEASE CIRCLE

Do you smoke cigarettes?	Yes	No	Never smoked		How many packs per day?	Year quit?	
Do you use other tobacco products?	Yes	No	Never used		Snuff / Chew	Year quit?	
Do you drink alcohol?	Yes	No	How many drinks per week?				
Do you use recreational or street drugs	Yes	No	Type				

Patient Name : _____

REVIEW OF SYSTEMS: Please check yes or no

General

Yes	No	
☐	☐	Chills
☐	☐	Fever
☐	☐	Night Sweats
☐	☐	Weight Gain
☐	☐	Weight Loss

HEENT

☐	☐	Congestion
☐	☐	Headache
☐	☐	Hoarseness
☐	☐	Hearing Problems
☐	☐	Visual Problems

Gastrointestinal

☐	☐	Abdominal Pain
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Excessive Appetite
☐	☐	Heartburn
☐	☐	Vomiting Blood
☐	☐	Black Stools (Melena)
☐	☐	Yellow Skin
☐	☐	Rectal Bleeding
☐	☐	Nausea
☐	☐	Vomiting

Cardiovascular

Yes	No	
☐	☐	Chest Pain
☐	☐	Irregular Heartbeat (Arrhythmia)
☐	☐	Palpitations (Rapid Heartbeat)
☐	☐	Swollen Ankles (Pedal Edema)

Genitourinary

☐	☐	Incontinence
☐	☐	Painful Urination (Dysuria)
☐	☐	Frequent Urination (Frequency)
☐	☐	Blood in Urine (Hematuria)
☐	☐	Need to Awaken to Urinate (Nocturia)
☐	☐	Urgent Urination (Urgency)

Pulmonary

☐	☐	Coughing
☐	☐	Coughing up Blood (Hemoptysis)
☐	☐	Shortness of Breath
☐	☐	Apnea
☐	☐	Wheezing

Endocrine

Yes	No	
☐	☐	Cold Intolerance
☐	☐	Heat Intolerance
☐	☐	Excessive Thirst (Polydipsia)
☐	☐	Excessive Urination (Polyuria)

Lymphatic

☐	☐	Lymph Node Swelling
☐	☐	Easy Bleeding

Neurological

☐	☐	Loss of Consciousness
☐	☐	Headaches
☐	☐	Dizziness
☐	☐	Seizures (Fits)
☐	☐	Fainting Spells

Skin

☐	☐	Rash
☐	☐	Lesions

Psychiatric

☐	☐	Anxiety
☐	☐	Depression

Infections

☐	☐	Staph
☐	☐	Other _____

FEMALES

☐ ☐ **Are you pregnant?**

Date of last menstrual cycle:

_____

DOMINANCE: **Right Hand or Left Hand** **HEIGHT:** _____ **WEIGHT:** _____

Patient Name:_____

MEDICATIONS: ***Please list your current medications, not previously listed on page 1***

Medication/Dosage	Reason for use

Signature: _____ Date:_____
(I certify that the information provided above is accurate and true)

Reviewed by: _____ Date: _____