HOUSTON Methodist
ORTHOPEDICS & SPORTS MEDICINE

Last Name:	First Name:	Age/Birthdate:
Email Address:	Pharmacy Phone and Address:	
Best Contact Number:	Alternate Phone Number:	
Occupation/Company:		
Work status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Disabled ☐ Volunteer ☐ Student ☐ Currently Unemployed		
Students only:	School:	Grade:

Primary Care Physician and address_____ Last visit date:___ /___ /_____

Current Height: _____ Current Weight:_____ Hand Dominance: ☐ Right ☐ Left ☐ Ambidextrous

Description of Injury/Symptoms: (Please circle or print)

1. **Location** of the injury/problem: **Right/Left/Bilateral** (Arm, Shoulder, Elbow, Forearm, Wrist, Hand, Thumb, Index Finger, Middle Finger, Ring Finger, Small Finger_____
2. **What** is your symptom: pain/injury/numbness/deformity/loss of mobility/weakness/other:_____
3. **Date** of injury/when symptoms began:_____
4. **How** the injury occurred/symptoms began:_____
5. **Where** the injury occurred home/work/auto/other:_____
6. **Severity** of your pain/symptoms: none/mild/moderate/severe?
7. Are your symptoms: improving/worsening/same?
8. **Describe** the symptoms: sharp/dull/aching/throbbing/burning/constant/intermittent/other:_____
9. Do you have any **associated**: swelling/bruising/numbness/tingling/snapping/deformity/weakness/stiffness/ open wounds/redness/other:_____
10. **When** do the symptoms occur: activity/sleeping/morning/work/driving/other:_____
11. **What improves** the symptoms: rest/ice/heat/brace/injection/medication/other:_____
12. **Medications tried** for symptoms: none/over-the-counter:_____Rx:_____topical:_____
13. **Previous test(s)**: x-rays, nerve test, MRI, CT, other:_____

Medical History: Have you had any of the following medical conditions? (Please circle)

Anemia	Diabetes	High Blood Pressure	Neurologic Condition	Bladder Infection
Blood Clot	Chest Pain	Hypothyroidism	Migraines	Currently Pregnant
Asthma	HIV	Hepatitis A, B, C	Bleeding Ulcer	Previously Pregnant
Kidney Problem	Liver Problems	Heart Attack	Lung Problem	Vascular disease
Cancer type:_____	Depression	Heart Problem:_____	Rheumatoid Cond.	Stroke
Skin/Staph Infection	Anxiety	Heart Stent	History of Seizures	NONE
High Cholesterol	Sleep Apnea	Bleeding Disorder	Reflux	

Drug and/or Food Allergies: (Please list):_____

Are you allergic to any of the following? (please circle)**:** latex, adhesive tape, anesthesia, iodine, IV contract, none

Medications: Please list below or check this box if you have none: ☐ None

Name	Dosage	Frequency

Surgical History: Please list below or check this box if you have none: ☐ None

Surgeries or Hospitalizations	Year	Complications (if any)

Review of Systems: Have you experienced any of the following recently? Please circle all that apply.

Fever, chills, fatigue, sleep problems, blurry vision, double vision, decreased hearing, sore throat, ears ringing, chest pain, fainting, shortness of breath, cough, heartburn, nausea, vomiting, constipation, diarrhea, rectal bleeding, pain with urination, incontinence, increased frequency, joint swelling, cramps, weakness, rash, itching, numbness, tingling, loss of balance, seizures, anxiety, depression, weight change, continuous thirst, rash, hay fever, easy bruising, easy bleeding, swelling, enlarged lymph nodes

Immunizations: Are your immunizations up to date? ☐ Yes ☐ No ☐ I'm not sure

Tetanus (Year)?	Flu Shot (Year)?	Pneumonia Vaccine (Year)?

Family History: Do any of the following diseases run in your family? (Please explain)

Disease:	Mother	Father	Siblings	Children
Heart disease / heart attack				
High blood pressure				
Diabetes				
Cancer (type):				
Bleeding disorders				
Seizures				
Mental illness				
Stroke				
NONE or List Other				

Social History / Habits: (Please circle and provide further information if applicable)

Do you smoke cigarettes?	Yes	No	Packs per day?		For how many years?		Year quit?	
Do you use other tobacco products?	Yes	No	Type:		For how many years?		Year quit?	
Do you drink alcohol?	Yes	No	How many drinks per week?					
Do you use recreational or street drugs?	Yes	No	Type					

Describe your overall health:	**Excellent**	**Good**	**Fair**	**Poor**
List sports, exercise, hobbies:				

Patient Signature:_____ Date:_____ Physician /PA signature:_____