

ALLSTAR ORTHOPEDICS

PATIENT HISTORY

WELCOME TO OUR PRACTICE. PLEASE FILL OUT THE INFORMATION BELOW.

TODAYS DATE _____

PATIENT NAME _____ AGE _____ DOB _____

CHIEF COMPLAINT _____

PAST MEDICAL HISTORY

HAVE YOU EVER HAD THE FOLLOWING? PLEASE CHECK ALL PERTINENT BOXES:

- | | |
|--------------------------|-----------------------------|
| _____ MEASLES | _____ GLAUCOMA |
| _____ MUMPS | _____ BLOOD TRANSFUSIONS |
| _____ CHICKENPOX | _____ BACK TROUBLE |
| _____ WHOOPING COUGH | _____ HIGH BLOOD PRESSURE |
| _____ SCARLET FEVER | _____ LOW BLOOD PRESSURE |
| _____ DIPHTHERIA | _____ ASTHMA |
| _____ SMALLPOX | _____ AIDS OR HIV+ |
| _____ PNEUMONIA | _____ INFECTIOUS MONO |
| _____ RHEUMATIC FEVER | _____ BRONCHITIS |
| _____ HEART DISEASE | _____ MITRAL VALVE PROLAPSE |
| _____ ARTHRITIS | _____ STROKE |
| _____ VENEREAL DISEASE | _____ HEPATITIS |
| _____ ANEMIA | _____ ULCER |
| _____ BLADDER INFECTIONS | _____ KIDNEY DISEASE |
| _____ EPILEPSY/SEIZURES | _____ THYROID DISEASE |
| _____ MIGRAINE HEADACHES | _____ BLEEDING TENDENCY |
| _____ TUBERCULOSIS | _____ OTHER: (please list) |
| _____ DIABETES | _____ |
| _____ CANCER | _____ |
| _____ POLIO | _____ |

PAST SURGICAL HISTORY

:

Please list previous Hospitalizations/Surgeries/When?/Doctor

MEDICATIONS

: (Please include non-prescription)

ALLERGIES

:

OFFICE USE ONLY: UPDATED AND REVIEWED/INITIALS

Patient Social History:

Marital Status	Use of Alcohol	Use of Tobacco	Living Situation	Dominate Hand
<input type="checkbox"/> Single	<input type="checkbox"/> Never	<input type="checkbox"/> Never	<input type="checkbox"/> With Family	<input type="checkbox"/> Right
<input type="checkbox"/> Married	<input type="checkbox"/> Rarely	<input type="checkbox"/> Previously, but quit	<input type="checkbox"/> With Friends	<input type="checkbox"/> Left
<input type="checkbox"/> Divorced	<input type="checkbox"/> Moderate	<input type="checkbox"/> Currently	<input type="checkbox"/> Alone	
<input type="checkbox"/> Widowed	<input type="checkbox"/> Daily		<input type="checkbox"/> Other	
<input type="checkbox"/> Separated		_____ Packs Per Day	_____	

Family Medical History

	Age	Conditions or Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
_____	_____	_____	_____

Review of Systems: Please indicate any personal history below:

General		Gastrointestinal		Rheumatologic	
Change in weight, unexplained	No Yes	Abdominal pain	No Yes	Arthritis or joint pain	No Yes
Joint stiffness or swelling	No Yes	Nausea or vomiting	No Yes	Swollen warm joints	No Yes
Fever	No Yes	Constipation or diarrhea	No Yes	Morning stiffness	No Yes
Fatigue	No Yes	Loss of appetite	No Yes		
		Unexplained weight change	No Yes	Neurological	
HEENT		Bloody or tarry stools	No Yes	Numbness	No Yes
Headaches	No Yes	Coughing blood	No Yes	Weakness	No Yes
Dizziness	No Yes			Seizures	No Yes
Blurred vision	No Yes	Genitourinary			
Double vision	No Yes	Frequent urination	No Yes	Breasts	
ringing of ears	No Yes	Urgency, or hesitancy	No Yes	Masses	No Yes
Hearing difficulties	No Yes	Bloody urine	No Yes	Tenderness	No Yes
		Kidney stones	No Yes	Nipple discharge	No Yes
Respiratory		Frequent urinary tract infections	No Yes		
Shortness of breath w/exertion	No Yes			Skin	
Cough	No Yes	Endocrine		Rashes	No Yes
Bloody sputum	No Yes	Excessive urination at night	No Yes	New skin lesions	No Yes
Wheezing	No Yes	Heat or cold intolerance	No Yes	Change in size or color of moles	No Yes
		Palpations or nervousness	No Yes		
Cardiovascular				Allergic/Immunologic	
Chest Pain	No Yes	Hematological		List food/immunologic allergies	
Palpitations	No Yes	Anemia	No Yes	_____	
High Blood Pressure	No Yes	Enlarged lymph nodes	No Yes	_____	
Shortness of breath at night	No Yes	Easy bruising	No Yes	_____	

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor of any changes in my medical status. I also authorize the health care staff to perform the necessary services I may need.

Signature of Patient or Parent of Minor

Date