ZEIDERS orthopaedics
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PATIENT HISTORY FORM

Patient Name_____ Date_____

Height: _____ Weight: _____

Are you here for a second opinion? ☐ Yes ☐ No

Date symptoms began or date of injury _____

Location of the pain (ie shoulder, knee, etc.) _____ LEFT RIGHT

How did the injury happen?_____

Where? _____ What time? _____

Were you injured on the job? ☐ Yes ☐ No If yes, employer: _____

Have you been treated before for this injury? ☐ Yes ☐ No If yes, where: _____

Were x-rays or tests (CT/MRI, etc.) done? ☐ Yes ☐ No

Did you bring a CD or a report with you? ☐ Yes ☐ No

Able to continue activity or work? ☐ Yes ☐ No

If unable to work, please state the date you last worked: _____

Diagnosis given: _____ Treatment given:_____

Was surgery performed? ☐ Yes ☐ No (If so, please obtain report or let us know and we will try to do so)

Date of Surgery: _____ Surgery performed: _____

Describe your symptoms: ☐ Mild ☐ Moderate ☐ Severe ☐ Excruciating

What worsens the pain? _____

When is the pain worse? _____

What makes the pain better? _____

Please describe the history of your symptoms. If this is an accident or injury, please provide in DETAIL a description of events, including exact dates, happenings, where they occurred and how things transpired in your own words. Please be specific. _____

_____

Referral Source: ☐ **Physician** ☐ **Hospital** ☐ **Friend** ☐ **Yellow Pages** ☐ **Social Media** ☐ **Insurance Company**

Name: _____ Phone: _____

Primary Care Physician:

Name: _____ Phone: _____

Pharmacy:

Name: _____ Phone: _____

Patient Name_____ Date_____

PLEASE LIST ALL MEDICATIONS including creams, inhalers, herbal supplements and over-the-counter medications

MEDICATION	DOSE	FREQUENCY

Are you allergic to Latex? ☐ yes ☐ no

PLEASE LIST ALL DRUG AND NON-DRUG ALLERGIES ☐ no known allergies

ALLERGY	REACTION OR INTOLERANCE

PLEASE LIST ALL SURGERIES AND DATE OF OCCURANCE ☐ no previous surgeries

Surgery	Date

PLEASE LIST ANY HOSPITALIZATIONS AND DATE OF OCCURANCE ☐ no previous hospitalizations

Reason for admission	Facility	Date

FAMILY HISTORY

Father ☐ Living ☐ Deceased

- ☐ Anesthetic Reaction
- ☐ Arthritis
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Osteoporosis
- ☐ Stroke

Mother ☐ Living ☐ Deceased

- ☐ Anesthetic Reaction
- ☐ Arthritis
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Osteoporosis
- ☐ Stroke

Siblings ☐ Living ☐ Deceased

- ☐ Anesthetic Reaction
- ☐ Arthritis
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Osteoporosis
- ☐ Stroke

Patient Name_____ Date_____

SOCIAL HISTORY

Have you traveled outside the US in the past 10 years? ☐ Yes ☐ No If yes, where? _____

Do you drink alcohol? ☐ Never ☐ Occasionally ☐ Daily

Do you Smoke? ☐ Non-smoker ☐ Former Smoker ☐ Current Smoker

Packs per day or type of Nicotine other than cigarettes _____

Are you currently pregnant? ☐ Yes ☐ No ☐ N/A

Recreational drug use? ☐ Never ☐ Previously ☐ Currently

Exercise regularly? ☐ Yes ☐ No

Marital status? ☐ Single ☐ Married ☐ Divorced ☐ Widowed

PAST MEDICAL HISTORY- Have you previously been diagnosed with any of the following:

☐ Acid Reflux	☐ Blood Disease	☐ Headache	☐ Neck/ Back problems
☐ Allergies	☐ Bronchitis	☐ Heart Attack	☐ Paralysis
☐ Allergies Seasonal	☐ Cancer	☐ Heart Disease	☐ Seizures
☐ Anemia	☐ Depression	☐ Hepatitis	☐ Stroke
☐ Anxiety	☐ Diabetes	☐ HIV/ AIDS	☐ Thyroid Disease
☐ Asthma	☐ Emphysema	☐ High Blood Pressure	☐ Other: _____
☐ Back pain	☐ Glaucoma	☐ Lung/ breathing problems	_____
☐ Blood clots	☐ Gout	☐ Kidney/urinary problems	_____

REVIEW OF SYSTEMS- Are you currently having these problems?

Constitutional

Fatigue	☐ Yes	☐ No
Fever	☐ Yes	☐ No
Night sweats	☐ Yes	☐ No

HEENT

Hoarseness	☐ Yes	☐ No
Nose Bleed	☐ Yes	☐ No

Cardiology

Chest pain	☐ Yes	☐ No
Leg swelling	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No

Neurology

Headache	☐ Yes	☐ No
Loss of feeling in legs	☐ Yes	☐ No
Numbness	☐ Yes	☐ No
Seizures	☐ Yes	☐ No

Respiratory

Blood-tinged sputum	☐ Yes	☐ No
Cough	☐ Yes	☐ No
Wheezing	☐ Yes	☐ No

Dermatology

Rash	☐ Yes	☐ No

Urology

Blood in urine	☐ Yes	☐ No
Recurrent UTI	☐ Yes	☐ No

Hematology

Abnormal Bleeding	☐ Yes	☐ No

Musculoskeletal

Bone pain	☐ Yes	☐ No
Joint pain	☐ Yes	☐ No
Joint redness	☐ Yes	☐ No
Joint stiffness	☐ Yes	☐ No
Leg Cramps	☐ Yes	☐ No
Muscle pain	☐ Yes	☐ No
Muscle stiffness	☐ Yes	☐ No

Psychology

Depression	☐ Yes	☐ No

Gastroenterology

Abdominal pain	☐ Yes	☐ No
Black stools	☐ Yes	☐ No
Blood in stool	☐ Yes	☐ No
Heartburn	☐ Yes	☐ No
Nausea	☐ Yes	☐ No