BAY AREA ORTHOPAEDICS & SPORTS MEDICINE

Patient History & Data Base Form

Name: _____ Age: _____ Date: _____

Occupation: _____ Referred by: _____

Description of job duties: _____

_____

School: _____ Sports you play regularly: _____

HISTORY OF PRESENT PROBLEM

Symptoms/Presenting Problem: _____

Date of Injury: _____ Problem first started about: _____

This occurred at: Work ___ home ____ motor vehicle ____ other: _____

Describe how you were injured: _____

_____

P Location of your pain: _____

A Usual severity of pain: 1 2 3 4 5 6 7 8 9 10 (Please circle, worst pain = 10)

I Severity of pain today 1 2 3 4 5 6 7 8 9 10 (Please circle, worst pain = 10)

N Type of pain: dull ___ burning____ aching _____ throbbing ____ sharp ____ (indicate all appropriate)

Other type of pain describe: _____

Is WORSE by: Moving ____ lifting _____ twisting ____ walking _____ running _____

Other: _____

Get RELIEF by: _____

Is pain as bad at night? Y _____ N _____ Hours of sleep you now usually get: _____

Is pain affecting your ability to sleep? Y ____ N _____ Sometimes _____

TREATMENT

Treatment you have had: None _____ Medication(s) _____

Physical Therapy: _____ How long? _____

Date stopped working _____ I'm still working _____

PAST HEALTH HISTORY

Check if you have ever had:

__ Diabetes	__ Asthma	__ Kidney/bladder disease
__ High blood pressure	__ Chronic Cough	__ Blood clots in legs
__ Irregular heart beat	__ Ulcers	__ Bleeding disorder
__ Angina	__ Hiatal hernia	__ Infected/bleeding gums
__ Emphysema/lung disease	__ Jaundice/hepatitis	__ Stroke
__ Heart attack/disease	__ Depression	__ Thyroid Disease

___ Surgical Complications (please list) _____

_____

__ Cancer of: _____

PLEASE TURN FORM OVER TO CONTINUE

BAY AREA ORTHOPAEDICS & SPORTS MEDICINE

Other Medical Problems or details about past health history: _____

_____

_____

Please list any surgeries you have had, with approximate dates:

Surgery	Date	Surgery	Date

Please list any **ALLERGIES** to Medicine and type of reaction:

_____

HABITS

Smoking: _____ packs/day x _____ years. If quit, how long ago? _____ Never smoked _____

Drink Number of _____ beers _____ glasses of wine _____ cocktails per day _____

CURRENT MEDICATION

Please list any medication you currently take on a regular basis: _____

_____

_____

_____

_____

_____ _____

Signature of Patient (or parent if patient is under 18 years of age) Date