Alabama Orthopedic, Spine & Sports Medicine Associates
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PATIENT HISTORY

Please PRINT and fill out completely.

Name:_____ Today's Date:_____

Age:_____ Height:_____ Weight:_____ Hand Dominance: ❑ Left ❑ Right

HISTORY OF INJURY

Did the problem result from a specific injury? ❑ Yes ❑ No **Injury/Accident Date**:_____

Did your problems begin following: ❑ Work injury? ❑ Motor Vehicle Accident? **What State**?_____

How did you get injured? _____

If neither, how long have you had the condition? _____

Please rate your pain on a scale of 1 to 10 *(10 being the most painful)*: _____

Is the pain: ❑ Constant ❑ Occasional ❑ Sharp ❑ Dull ❑ Aching ❑ Stabbing ❑ Throbbing

What symptoms are you experiencing? ❑ Locking ❑ Catching ❑ Giving Way ❑ Popping ❑ Grinding ❑ Other

What, if anything, makes your symptoms *better*? _____

What, if anything, makes your symptoms *worse*? _____

Have you seen another physician for this injury? ❑Yes ❑No

If yes, who? _____

What treatments have you tried? ❑ Nothing ❑ Physical Therapy ❑ Exercise ❑ Acupuncture
❑ Chiropractic ❑ Injections (specify: ESI, Facets, Sacroiliac, Selective Nerve Root Block, Synvisc, Hyalgan)
❑ Medications_____ ❑ Other _____

Have you had any of the following tests?

Test	*Date (month/year)*	*What facility? (clinic/hospital)*
❑ X-rays	_____	_____
❑ MRI scan	_____	_____
❑ CT scan	_____	_____
❑ EMG/NCV	_____	_____
❑ Discogram	_____	_____
❑ EKG	_____	_____
❑ Blood tests	_____	_____
❑ Other	_____	_____

Regular Exercise: ❑ Yes ❑ No Type of exercise and activity you enjoy: _____
_____
_____

Health History- page 2
Patient name_____

Practitioner's Initials:_____

PAST SURGICAL HISTORY

Please check any previous surgical procedures, list the date and describe surgery:

❑ Appendectomy ❑ Hernia Repair ❑ Arthroscopy Lower extremity ❑ Upper extremity
❑ Spine/Back Surgery ❑ Heart Surgery ❑ Total Joint Replacement ❑ Fracture Repair
❑Other:_____
_____

SOCIAL HISTORY

Special Diet: ❑ Yes ❑ No Any restrictions?_____
Tobacco Use: ❑Yes ❑No Type:_____ Duration:_____ Quit Date:_____
Alcohol Use: ❑Yes ❑No Frequency:_____
Drug Use: ❑Yes ❑No Frequency:_____
Caffeine Use: ❑Yes ❑No Frequency:_____

ALLERGIES

Are you allergic to any medication? **Sulfa** ❑Yes ❑No **Latex** ❑Yes ❑No ❑No known drug allergies
Please list all medications that you are allergic to:_____
_____

MEDICAL HISTORY

Please check current or previous medical conditions:

❑ Anemia ❑ Depression ❑ Hepatitis A or B ❑ Osteoporosis
❑ Arthritis ❑ Diabetes ❑ High Blood Pressure ❑ Rheumatoid Arthritis
❑ Asthma ❑ Emphysema ❑ HIV ❑ Stroke/Seizures
❑ Blood Clots ❑ Heart Disease ❑ Irregular Heartbeat ❑ Thyroid
❑ Cancer ❑ Liver Disease ❑ Chemical Dependency and/or Alcoholism
❑ Other_____

Have you ever had a blood transfusion? ❑Yes ❑No If yes, when? _____

MEDICATIONS

Please list all medications you are currently taking. Include antibiotics, blood thinners, insulin, heart medications, aspirin, and any over the counter medications. Include Vitamin, Mineral and Herb supplements.

Medication	*Dosage*	*Frequency*

GASTROINTESTINAL HISTORY

Do you have a history of Peptic Ulcer Disease? ❑Yes ❑No If yes, when? _____

Do you have a history of GI, stomach bleed? ❑Yes ❑No If yes, when? _____

Do you take any medications for your stomach? *(Please include over the counter medications; i.e. Pepcid, Tums, Zantac, etc., dosage and frequency).* _____

Have you ever taken anti-inflammatory medicine for a period greater than 30 days? *(Please include over the counter medications such as Advil, Aleve, and previously prescribed medications, such as Celebrex, and Vioxx. List all you have tried).*

_____

Practitioner's Initials:_____

FAMILY HISTORY

Please check family history conditions:

❑ Blood Clots ❑ Diabetes ❑ Hypertension ❑ Rheumatoid Arthritis
❑ Cancer ❑ Heart Disease ❑ Osteoporosis ❑ Stroke / Seizures

Please describe any immediate family history of medical problems: _____

_____

_____

REVIEW OF SYSTEMS

Check if you have current symptoms or current known medical problems in the following areas. Please describe. If you do not have any problems please check in the negative box.

1. CONSTITUTIONAL GENERAL ❑ None ❑ Weight loss ❑ Weight Gain ❑ Insomnia ❑ Chronic Fatigue ❑ Other_____

2. EYES ❑ None ❑ Vision change ❑ Glasses/Contacts ❑ Cataracts ❑ Glaucoma ❑ Other_____

3. EARS, NOSE, THROAT ❑ None ❑ Loss of hearing ❑ Seasonal Allergies ❑ Sinus Pain ❑ Ringing ❑ Other_____

4. CARDIOVASCULAR ❑ None ❑ Chest Pain ❑ Edema ❑ Hypertension ❑ Palpitations ❑ High cholesterol ❑ Other_____

5. RESPIRATORY ❑ None ❑ Asthma ❑ Wheezing ❑ Frequent Cough ❑ Other_____

6. GASTROINTESTINAL ❑ None ❑ Heartburn ❑ Indigestion ❑ Acid Reflex ❑ Ulcer Problems ❑ Abdominal Pain ❑ Peptic Ulcer ❑ GI, Stomach Bleed ❑ Other_____

7. MUSCULOSKELETAL ❑ None ❑Arthritis ❑ Muscle Weakness ❑ Joint Pain ❑ Back Pain ❑ Other_____

8. SKIN ❑ None ❑ Rash ❑ Ulcers ❑ Scars ❑ Other_____

9. NEUROLOGICAL ❑ None ❑ Headaches ❑ Seizures ❑ Numbness ❑ Dizziness ❑ Other_____

10. PSYCHIATRIC ❑ None ❑ Depression ❑ Crying ❑ Anxiety ❑ Mood Swing ❑ Other_____

11. ENDOCRINE ❑ None ❑ Diabetes ❑ Hypothyroid ❑ Hyperthyroid ❑ Hot Flashes ❑ Other_____

12. HEMATOLOGY ❑ None ❑ Easy Bruising ❑ Bleeding ❑ Anemia ❑ Other_____

Signature:_____ Date:_____

Print name:_____