The Orthopaedic and Sports Medicine Center L.L.C.
Leaders in Specialty Orthopaedic Care

Patient Personal History Form

Patient Name: _____ **Today's Date**: _____

D.O.Birth: _____ **Sex**: _____ **Height / Weight**: _____ / _____ **Marital Status**: S M D W Other

Currently Employed? ☐No ☐Yes: *FT - PT* ☐Retired (*Former Occupation*:_____) ☐Minor *(Student? Grade:_____)*

Occupation/Employer: _____ Location: _____

Primary Care Physician:_____ Location: _____

Referring Provider: _____ Location: _____

Pharmacy Name:_____ Address:_____ Phone: ( ) _____ - _____

Social History

Alcohol use? ☐No ☐Yes *(_____drinks/wk.)*

Tobacco use? ☐Never ☐Former *(Quit Date:_____)* ☐Currently (Type_____ Amt/wk:_____)
Counseling Given ☐ Yes ☐ No

History of substance use? ☐No ☐Currently ☐Former use (Substances used:_____ Quit date:_____)

IV drug user? ☐No ☐Currently ☐Former (Drugs used:_____ Quit date:_____)

Medication Allergies or Other Notable Allergies/ Reaction that occurs:

Current Medications: ☐ Please see attached medication list.

Personal Health History

Have you *recently* had any of the following: ☐ Fever ☐ Chills ☐ Nausea ☐ ShortnessOfBreath ☐ ChestPain

*If yes, when?:*_____

Please check all that apply to you. Please include any previously diagnosed conditions that are regulated or under control with medication, etc.

Medical History			
☐ Allergies ☐ Depression ☐ Osteoporosis ☐ Asthma ☐ Glaucoma ☐ Substance abuse ☐ CHF ☐ Kidney Disease	☐ COPD ☐ Nerve/muscle disease ☐ Arthritis ☐ GER ☐ Stroke ☐ Cataracts ☐ HIV/AIDS ☐ Ulcers	☐ Meningitis ☐ Anxiety ☐ Emphysema ☐ Sickle cell ☐ Cancer ☐ Heart murmur ☐ Tuberculosis ☐ Hypertension	☐ Anemia ☐ Diabetes Mellitus ☐ Seizures ☐ Blood Transfusion ☐ Heart Attack ☐ Thyroid Disease ☐ Clotting Disorder ☐ Hyperlipidemia

☐ Pacemaker ☐ Chest Pain/Angina ☐ Heart Valve Disease ☐ Irregular Heart Beat ☐ High Cholesterol ☐ High Blood Pressure ☐ Poor Vision ☐ Hearing Loss ☐ Swallowing Issues ☐ Meniere's Disease	☐ Chronic Bronchitis ☐ Thalassemia ☐ Bleeding Disorder ☐ Hepatitis ☐ Stomach Ulcer ☐ Reflux/Heartburn ☐ Crohn's Diseases ☐ Cirrhosis ☐ Liver disease	☐ Lupus ☐ Hypothyroid ☐ Hyperthyroid ☐ Adrenal Disease ☐ Pituitary Disease ☐ Kidney Failure ☐ Kidney Stones ☐ Prostate Disease ☐ Multiple Sclerosis ☐ Parkinson's Disease	☐ Rhematoid Arthritis ☐ Osteoarthritis ☐ Fibromyalgia ☐ Lyme Disease ☐ Joint Pain ☐ Gout ☐ Tick bites ☐ MRSA/Staph ☐ Diabetes

Surgical History		
☐ Appendectomy ☐ Brain Surgery ☐ Breast Surgery ☐ CABG ☐ Cholecystectomy ☐ Colon Surgery ☐ Cosmetic Surgery	☐ C-Section ☐ Eye Surgery ☐ Fracture Surgery ☐ Hernia Repair ☐ Hysterectomy ☐ Joint Replacement	☐ Prostate Surgery ☐ Small Intestine Surgery ☐ Spine Surgery ☐ Tubal Ligation ☐ Valve Replacement ☐ Vasectomy

Please list any other issues or condition(s) for which you take medication:
