HUGHSTON CLINIC
ORTHOPAEDICS

For Office Us

PATIENT MEDICAL HISTORY & PAIN FORM

Full Name: _____ Today's Date: _____

Age: _____ Date of Birth: _____ Occupation: _____

Hughston Clinic Orthopaedics Doctor: _____

VITALS: Height: _____ Weight: _____

CHIEF COMPLAINT:

What hurts? _____ ☐ Left ☐ Right

HISTORY OF PRESENT ILLNESS:

Who referred you? _____ Name of Family Doctor: _____

When did your symptoms begin? _____

Where? (example: home, work) _____

Is this work-related? ☐ Yes ☐ No Other injury? ☐ Yes ☐ No

If this was a work-related injury, what was the date of injury? _____

If this was a work-related injury, was the injury reported to your employer? ☐ Yes ☐ No

Comments: _____

How did your symptoms start? _____

What are your symptoms? _____

What makes the pain better? _____

What makes the pain worse? _____

On a scale of 1–10, rank your pain (10 is the worst) 1 2 3 4 5 6 7 8 9 10

List the tests you have had done (X-rays, CAT Scans, MRI Scans, EMGs, etc.) _____

_____

_____

List the treatment you have had for this condition (medication, physical therapy, chiropractic, injections, surgery, etc.)

_____

_____

MEDICAL HISTORY:

➢ Please check ✓ all the boxes below that name the conditions that apply to you.

☐ No Previous Medical Problems

Medical Problems:			Recent Medical Tests:
☐ Asthma	☐ Heart attack	☐ Skin disease	☐ Blood work
☐ Blood Clot	☐ High blood pressure	☐ Sleep Apnea	☐ Bone Scan
☐ Cancer	☐ High cholesterol	☐ Stroke	☐ CT scan
☐ Depression	☐ Kidney problems	☐ Thyroid	☐ EMG
☐ Diabetes	☐ Lung problems	☐ Ulcers	☐ MRI
☐ Drug dependency	☐ Osteoporosis	☐ Other: _____	☐ X-ray
☐ Epilepsy	☐ Prostate problems	_____	☐ Other: _____
☐ Gout	☐ Rheumatoid Arthritis	_____	_____

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Name: _____ Today's Date: _____

PAST SURGICAL HISTORY:

➢ Please check ✓ all the boxes below that name the conditions that apply to you.

☐ No Past Surgical History

Previous Surgeries:	Date	Hospital	Doctor
☐ Appendectomy			
☐ Cesarean Section			
☐ Gallbladder			
☐ Heart (open or bypass)			
☐ Hysterectomy			
☐ Joint surgery (arthroscopic or open) Which joint? _____			
☐ Spine surgery			
☐ Tonsillectomy			
☐ Other (please list) _____ _____			

MEDICATIONS: Pharmacy Name: _____ Phone: _____

➢ List the names of ALL medications that you take (including over-the-counter medicine), the dosage, and the frequency.

Name of Medication:	Dosage	Frequency
Example: Naprosyn	*375mg*	*1 tablet twice a day*

(If needed, continue listing medications on the back of this page)

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Name: _____ Today's Date: _____

ALLERGIES:

- List the names of ALL drug allergies that you have
  - ☐ No Known Drug Allergies

Drug Allergies:

Name of Drug:	Describe your reaction when you have taken the drug:

FAMILY MEDICAL HISTORY:

- Please describe below any illnesses found in the patient's blood relatives.
  - ☐ No Family Medical History

Illness:	Family Member(s): (Please list: Mother, Father, Brother, Sister, Maternal Grandmother or Grandfather, Paternal Grandmother or Grandfather, Aunt and/or Uncle)
Arthritis	
Bleeding Condition	
Cancer	
Diabetes	
Heart Disease	
Osteoporosis	
Scoliosis (curvature of the spine)	
Stroke	

SOCIAL HISTORY:

- Please check ✓ all the boxes below that apply to you.

Tobacco: ☐ Yes ☐ No Packages per day: _____ Years: _____

Age started: _____ Age stopped: _____

Alcohol: ☐ Yes ☐ No Frequency: _____ Years: _____

Age started: _____ Age stopped: _____

HUGHSTON CLINIC
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* 72957549w321 ClinDoc

Name: _____ Today's Date: _____

REVIEW OF SYSTEMS:

➢ Have you recently had any of the following problems? Please check ✓ all boxes below that apply to you.

Problem:		Yes	No	If yes, please explain
1. Constitutional (overall)	a. Weight gain			
	b. Weight loss			
	c. Fever			
	d. Chills			
	e. Night sweats			
2. Eyes	a. Vision change			
3. Head, Ears, Nose, Throat	a. Difficulty hearing			
	b. Hoarseness			
4. Breast	a. Breast masses			
5. Cardiovascular (heart)	a. Chest pain			
	b. Irregular heartbeat			
6. Respiratory (breathing)	a. Shortness of breath			
7. Gastrointestinal (digestion)	a. Stomach ulcers			
	b. Heartburn			
	c. Jaundice			
8. Genitourinary (urination)	a. Frequent urination			
	b. Painful urination			
9. Skin / Integument	a. Rash			
	b. Skin problems			
10. Neurological (nervous system)	a. Headaches			
	b. Numbness			
11. Musculoskeletal (muscles & bones)	a. Joint pain			
	b. Night pain			
12. Endocrine (hormones & glands)	a. Fatigue			
13. Psychiatric (emotions)	a. Depression			
13. Hematologic (blood)	a. Anemia			
	b. Bleeding disorders			
	c. Blood transfusion			

Additional Patient Comments: _____

Internal Use Only:

1. *Reviewed by* _____ *Date:* _____
2. *Reviewed by* _____ *Date:* _____
3. *Reviewed by* _____ *Date:* _____
4. *Reviewed by* _____ *Date:* _____