

TODAY'S DATE: _____

(This form is good for 1 year from above date).

TEMP: _____ BP: _____

HT: _____ P: _____

WT: _____ R: _____

GULF COAST ORTHOPAEDICS & PMR NEW PATIENT HISTORY AND PHYSICAL FORM

(For new patients and to be updated annually)

PATIENT'S NAME: _____

AGE: _____

CHIEF COMPLAINT: (Why you are here today) _____

HISTORY OF PRESENT ILLNESS:

- **Location** of pain/problem? _____
- **How long** have you had this problem? _____
- How did the problem **start**? _____
- How **often** do you have the pain? _____
- What makes it **worse**? _____
- What makes it **better**? _____
- What **associated problems** have you been having? _____
- What is the **severity** of your pain? Mark an **X** on the appropriate circle below:
 (No Pain) ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ (Extreme Pain)
- What does the pain **feel** like? (throbbing, shooting, sharp, etc) _____

GENERAL MEDICAL INFORMATION:

My general health is: (Please check one) Excellent Very Good Good Fair

Who is your family doctor: _____ Date of last visit: _____

Are you pregnant or attempting to get pregnant: YES NO

List any medications you are currently taking including strength and how often taken:

NAME	DOSAGE	HOW OFTEN	NAME	DOSAGE	HOW OFTEN
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Are you currently taking (or have you taken in the past) diet pills or herbal supplements? YES NO

If yes, write name of the pill/supplement and date last taken: _____

ALLERGIES:

List medications and/or foods that you are ALLERGIC to or have had a bad reaction to:

What kind of reaction did you have? _____

PAST MEDICAL HISTORY:

Check any problem you have ever been treated for and indicate the year of treatment:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Sickle Cell Anemia | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Lupus | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Hereditary Defects |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Brittle Bones | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Gall Stones | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Peripheral Vascular Disease | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Drug Dependency |
| <input type="checkbox"/> Ruptured Disc | <input type="checkbox"/> Stroke | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Head Injury |
| <input type="checkbox"/> Sciatica | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Polio | <input type="checkbox"/> Convulsions |
| <input type="checkbox"/> Spinal Curvature | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Fainting Spells |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Asthma | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Bladder Infection | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Gout |

SURGICAL/HOSPITALIZATION HISTORY:

PRIOR SURGERIES:

Type of Surgery

Date of Surgery

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PRIOR NON-SURGICAL HOSPITALIZATIONS, MAJOR ILLNESSES OR INJURIES:

Reason for Admit

Date of Admit

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

SOCIAL HISTORY:

Occupation: _____ Marital Status: S M W Dv Sp

Are you working now? _____ If no, when did you work last? _____

Place of Birth: _____ Grade of School Completed: _____

I live in a: House Apartment Condominium Mobile Home Boat

My home is: Single-Level Multi-Level # of stairs to enter: _____ # of stairs inside: _____

I live: Alone w/Spouse w/Parents w/Children Other _____

Alcohol Consumption:

Type: Beer Wine Whiskey None

Frequency: Daily Weekly Monthly Never

If you have quit, how long? _____

Tobacco Use:

Type: Cigarettes Pipe Chew None

How much used daily? _____

and for how long? _____

If you have quit, how long? _____

FAMILY HISTORY:

Mother: Living: YES or NO Age: _____ Condition of health: _____

If deceased, cause of death and age at death: _____

Father: Living: YES or NO Age: _____ Condition of health: _____

If deceased, cause of death and age at death: _____

Have you or any member of your family every had? (Indicate relative by placing a letter next to problem):

F-(father), **M**-(mother), **GF**-(grandfather), **GM**-(grandmother), **B**-(brother), **S**-(sister), **C**-(child), **U**-(uncle), **A**-(aunt)

- | | | |
|--|--|---|
| <input type="checkbox"/> CANCER | <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> HEART DISEASE |
| <input type="checkbox"/> HEART ATTACK | <input type="checkbox"/> DIABETES | <input type="checkbox"/> STROKE |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> SEIZURES | <input type="checkbox"/> TUBERCULOSIS (TB) |
| <input type="checkbox"/> KIDNEY PROBLEMS | <input type="checkbox"/> HEPATITIS | <input type="checkbox"/> ASTHMA |
| <input type="checkbox"/> EMPHYSEMA | <input type="checkbox"/> COPD | <input type="checkbox"/> LUPUS |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> OSTEOPOROSIS | <input type="checkbox"/> REACTION TO ANESTHESIA |
| <input type="checkbox"/> LUNG PROBLEMS | <input type="checkbox"/> BACK INJURY | <input type="checkbox"/> STOMACH PROBLEMS |
| <input type="checkbox"/> ULCERS | <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> SKIN BREAKDOWN |

SYMPTOM / SYSTEMS REVIEW:

If you have ever experienced any of the following problems, please check the problem and write the year you experienced it right next to the checked item OR check **NO PROBLEMS**.

GENERAL HEALTH / CONSTITUTIONAL SYMPTOMS

- Fatigue
- Difficulty sleeping
- Unexplained bleeding
- Fever/chills
- Night sweats
- Recent weight change
- Other _____
- NO PROBLEMS**

HEAD / FACE

- Headaches
- Lesions or scars
- Reduced facial strength
- Recent hair loss
- Masses
- Facial paralysis
- Scalp tenderness
- Other _____
- NO PROBLEMS**

EYES

- Blurred or double vision
- Dryness
- Redness of the eyes
- Visual disturbances
- Wear glasses or contacts
- Cataracts
- Glaucoma
- Other _____
- NO PROBLEMS**

EARS / NOSE / MOUTH / THROAT

- Earaches or drainage
- Bad breath or bad taste
- Bleeding gums
- Hearing loss
- Mouth sores/ulcers
- Frequent sore throat
- Ringing in the ears
- Difficulty swallowing
- Voice changes
- Sinus infections/problems
- Sinus tenderness
- Dryness of the mouth
- Nosebleeds
- Hayfever
- Dentures
- Other _____
- NO PROBLEMS**

NECK

- Masses
- Tenderness
- Thyroid tenderness
- Vein distention
- Swollen glands in the neck
- Pain
- Other _____
- NO PROBLEMS**

CHEST / BREAST

- Breast discharge
- Breast implants
- Breast lump
- Breast pain
- Other _____
- NO PROBLEMS**

CARDIOVASCULAR

- Chest pain or pressure
- Blood clots
- Swelling of feet and/or ankles
- Fast or irregular heart beat
- Palpitations
- Swelling of the hands
- Heart trouble
- Leg cramps
- Poor circulation
- Other _____
- NO PROBLEMS**

RESPIRATORY

- Wheezing
- Chronic or frequent coughs
- Cough with mucous production
- Difficulty breathing
- Dry cough
- Shortness of breath when lying flat
- Shortness of breath when walking
- Pain on breathing
- Spitting/coughing blood
- Other _____
- NO PROBLEMS**

SYMPTOM / SYSTEMS REVIEW (continued):

If you have ever experienced any of the following problems, please check the problem and write the year you experienced it right next to the checked item OR check **NO PROBLEMS**.

GASTROINTESTINAL

- Heartburn or indigestion
- Changes in bowel movements
- Rectal bleeding or blood in stool
- Painful bowel movements
- Constipation
- Loss of appetite
- Nausea or vomiting
- Abdominal pain
- Frequent diarrhea
- Stomach pain or cramps
- Other _____
- NO PROBLEMS**

GENITOURINARY

- Burning or painful urination
- Blood or pus in urine
- Vaginal discharge
- Incontinence or dribbling
- Pain with periods
- Sexual difficulty
- Genital rash or ulcers
- Irregular periods
- Testicular pain
- Change in force of strain when urinating
- Prostate problems
- Other _____
- NO PROBLEMS**

LYMPHATIC / HEMATOLOGIC

- Bleeding or bruising tendency
- Enlarged glands
- Phlebitis
- Slow to heal after cuts
- Other _____
- NO PROBLEMS**

MUSCULOSKELETAL / EXTREMITIES

- Back pain
- Cold extremities
- Difficulty climbing stairs
- Difficulty walking
- Joint pain
- Joint stiffness or swelling
- Numbness or tingling
- Paralysis
- Walk with a limp
- Walk with assistive device
- Walk only limited distances
- Weakness of muscles or joints
- Other _____
- NO PROBLEMS OTHER THAN REASON FOR VISIT**

NEUROLOGICAL / PSYCHIATRIC

- Convulsions or seizures
- Frequent/recurring headaches
- Numbness or tingling sensation
- Tremors
- Memory loss or confusion
- Light headed
- Loss of consciousness
- Feeling blue
- Dizziness
- Other _____
- NO PROBLEMS**

INTEGUMENTARY / SKIN

- Change in skin color
- Change in hair or nails
- Psoriasis
- Rash or itching
- Skin nodules or bumps
- Skin changes after sun exposure
- Other _____
- NO PROBLEMS**

PLEASE LIST OTHER PERTINENT INFORMATION YOUR PHYSICIAN SHOULD KNOW:

I hereby attest that I personally completed this form and all the information is true and correct.

Signature of Patient or Guardian completing form **Date**

HISTORY FORM REVIEWED BY: _____ DATE: _____
PHYSICIAN'S OR PHYSICIAN ASSISTANT'S SIGNATURE