

TODAY'S DATE: _____
(This form is good for 1 year from above date).



Sacred Heart Orthopedics

Sacred Heart Medical Group

PATIENT PROVIDED MEDICAL HISTORY

(For new patients and to be updated annually)

YOUR NAME: _____

AGE: _____

YOUR 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 make 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, ect) _____

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:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Diet Pills and Herbal Supplements: _____

ALLERGIES:

MEDICATION:

REACTION:

PAST MEDICAL HISTORY:

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

- | | | |
|---|--|---|
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> DVT (blood clots in legs) | <input type="checkbox"/> Kidney Failure/insufficiency |
| <input type="checkbox"/> Lupus | <input type="checkbox"/> Pulmonary Embolus (PE) | <input type="checkbox"/> Bladder Infection |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Kidney Infection |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> GERD / Reflux |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Heart valve disease | <input type="checkbox"/> Hyperthyroidism |
| <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Irregular heartbeat _____ | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Diabetes-insulin dependent | <input type="checkbox"/> High Cholesterol/Triglycerides |
| <input type="checkbox"/> Ruptured Disk | <input type="checkbox"/> Diabetes-noninsulin dependent | <input type="checkbox"/> Drug Dependency |
| <input type="checkbox"/> Degenerative disc | <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Sciatica | <input type="checkbox"/> Asthma | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Spinal Curvature | <input type="checkbox"/> Emphysema/COPD | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Hepatitis A B C | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Stroke / TIA | <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> PVD | <input type="checkbox"/> Gall Stones | <input type="checkbox"/> TB |
| <input type="checkbox"/> Polio | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Cancer _____ |
| <input type="checkbox"/> Other _____ | | |

Do you have a pacemaker: YES NO

PAST SURGICAL HISTORY: PRIOR SURGERIES:

Type of Surgery

Date of Surgery

_____	_____
_____	_____
_____	_____
_____	_____

HOSPITALIZATIONS:

_____	_____
_____	_____
_____	_____
_____	_____

SOCIAL HISTORY:

Occupation: _____ Marital Status: S M W DV SP
 Are you working now? _____ If no, when did you last work? _____
 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: _____
 I live: Alone w/spouse w/ others _____

Current Tobacco Use: YES or NO

Current Alcohol consumption: YES or NO

- | | |
|--|---|
| <input type="checkbox"/> 1/2 pk/day, <input type="checkbox"/> 1 pk /day, | <input type="checkbox"/> 0-2 daily, <input type="checkbox"/> 2-4 daily <input type="checkbox"/> more than 4/day |
| <input type="checkbox"/> more than 1 pk/day _____ | |

Do you feel safe in your environment? Y N

Walking with Aids Y N:

Type _____

FAMILY HISTORY:

Mother Living: YES or NO Age: _____ Condition of health: _____
Father Living: YES or NO Age: _____ Condition of health: _____
If deceased, cause of death and age of death: _____

Has any member of your family ever had?

- | | | |
|--|---|--|
| <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> TUBERCULOSIS (TB) |
| <input type="checkbox"/> HEART ATTACK | <input type="checkbox"/> DIABETES | <input type="checkbox"/> STROKE |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> COPD | <input type="checkbox"/> ASTHMA |
| <input type="checkbox"/> KIDNEY PROBLEMS | <input type="checkbox"/> OSTEOPOROSIS | <input type="checkbox"/> LUPUS |
| <input type="checkbox"/> EMPHYSEMA | <input type="checkbox"/> COPD | <input type="checkbox"/> ULCERS |
| <input type="checkbox"/> LUNG PROBLEMS | <input type="checkbox"/> HEART DISEASE | |
| <input type="checkbox"/> STROKE | <input type="checkbox"/> REACTION TO ANESTHESIA | |

REVIEW OF SYSTEMS:

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
- Reduced facial strength
- Masses
- Facial paralysis
- Other _____
- NO PROBLEMS**

EYES

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

EARS/NOSE/MOUTH/THROAT

- Earaches or drainage
- Bleeding gums
- Hearing loss
- Mouth sores/ulcers
- Frequent sore throat
- Difficulty swallowing
- Sinus tenderness
- Dryness of the mouth
- Bad teeth
- Nosebleeds
- Sinus infections/problems
- Dentures
- Other _____
- NO PROBLEMS**

NECK

- Masses
- Tenderness
- Thyroid tenderness
- 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
 - DVT
 - Swelling of feet or ankles
 - Fast or irregular heart beat
 - Palpitations
 - Heart trouble
 - Leg cramps
 - Poor circulation
 - Other _____
 - NO PROBLEMS**

SYMPTOM/SYSTEMS REVIEW: (continued):

RESPIRATORY

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

GASTROINTESTINAL

- Heartburn or indigestion
- Changes in bowel movements
- Rectal bleeding or blood in stool
- Difficulty breathing
- Dry cough
- Shortness of breath/lying flat
- Shortness of breath/walking
- Pain on breathing
- 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
- Difficult urination
- Prostate problems
- Other _____
- NO PROBLEMS**

MUSCULOSKELETAL/EXTREMITIES

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

LYMPHATIC / HEMATOLOGIC

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

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
- 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 completed form: _____ Date/Time: _____



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Nursing and Physician Use "Only"
Clinical Flow Sheet

NAME: _____

DOB: _____ Date: _____ Age _____

Ht: _____ Wt: _____ BMI _____

Injury Date: _____ Operation Date: _____

Pulse: _____ Resp: _____ BP: _____

Follow-up:

Notes:

X-Ray's ordered: _____

- | | | | | | | | |
|---|---|--|---|---|------------------------------------|---------------------------------------|---------------------------------|
| General: <input type="checkbox"/> Alert & Oriented PPT | <input type="checkbox"/> NL Mood & Affect | <input type="checkbox"/> WNWD | <input type="checkbox"/> Obese | <input type="checkbox"/> Grooming | <input type="checkbox"/> Deformity | <input type="checkbox"/> Scars | |
| Gait: <input type="checkbox"/> NL | <input type="checkbox"/> Antalgic | <input type="checkbox"/> Trendelenberg | Lymph: <input type="checkbox"/> Masses | <input type="checkbox"/> Nodes | | | |
| Pulses: <input type="checkbox"/> DP | <input type="checkbox"/> PT | <input type="checkbox"/> Hair Pattern | <input type="checkbox"/> Skin Changes | DTR: ___ Pat ___ | ___ Ach ___ | ___ Ham ___ | |
| Sensation: <input type="checkbox"/> Touch | <input type="checkbox"/> Sharp | <input type="checkbox"/> Vibratory | <input type="checkbox"/> Proprioception | Skin: <input type="checkbox"/> Lesions | <input type="checkbox"/> Edema ___ | <input type="checkbox"/> Varicosities | <input type="checkbox"/> Stasis |
| Aides: <input type="checkbox"/> Cane | <input type="checkbox"/> Crutch | <input type="checkbox"/> Walker | | | | | |

Provider Signature: _____

Nurse Signature: _____

Time and Date: _____