KERLAN-JOBE ORTHOPAEDIC CLINIC

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**PATIENT HISTORY** **DATE**_____

PATIENT NAME: _____ DOB: _____ AGE:_____
OCCUPATION: _____ SEX: ( ) **M** ( ) **F**

DOCTOR(S) WHO SENT YOU: _____DOMINANT HAND:( ) **RT** ( ) **LT**

(CC) Reason for Visit:

_____
_____

DETAILS OF INJURY: WHERE, WHEN AND HOW INJURY OCCURRED.

DATE OF INJURY_____ If not injury, give Date of Onset _____

Was injury or onset related to: **Work**: ( ) **Y** ( ) **N** **Auto Accident:** ( ) **Y** ( ) **N**

Other ( school, sports, activity or explain)_____

How did the injury/ problem occur? _____
_____
_____

What body parts were injured?_____
_____

Any previous treatment of the problem? (include any medications prescribed)

_____
_____
_____
_____

Is this injury potentially going to be in litigation: ( ) **Y** ( ) **N**

Name of Physician(s) who treated you: _____ When?
_____ _____
_____ _____

***HISTORY OF PRESENT ILLNESS***

A) Location of your pain? (e.g low back, neck, groin, buttock, right or left knee, calf, right or left shoulder, right or left elbow, wrist, foot pain, heel, other)

_____
_____
_____

B) Severity of your pain? Mark the point on the line between 0 (least) and 10 (worst) which best describes how severe current pain is.

**0 1 2 3 4 5 6 7 8 9 10**

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C) Character of the pain? (e.g Dull, Sharp, Achy, Burning, Throbbing, Crampy, Shooting, Incapacitating, Prickly, Stabbing, Other)

_____

D) When do you feel pain and for how long does it last?
(Morning, afternoon, Evening, increases over the day, Bending, Climbing, Squatting. Is the pain constant, how long does it last?)

_____
_____
_____

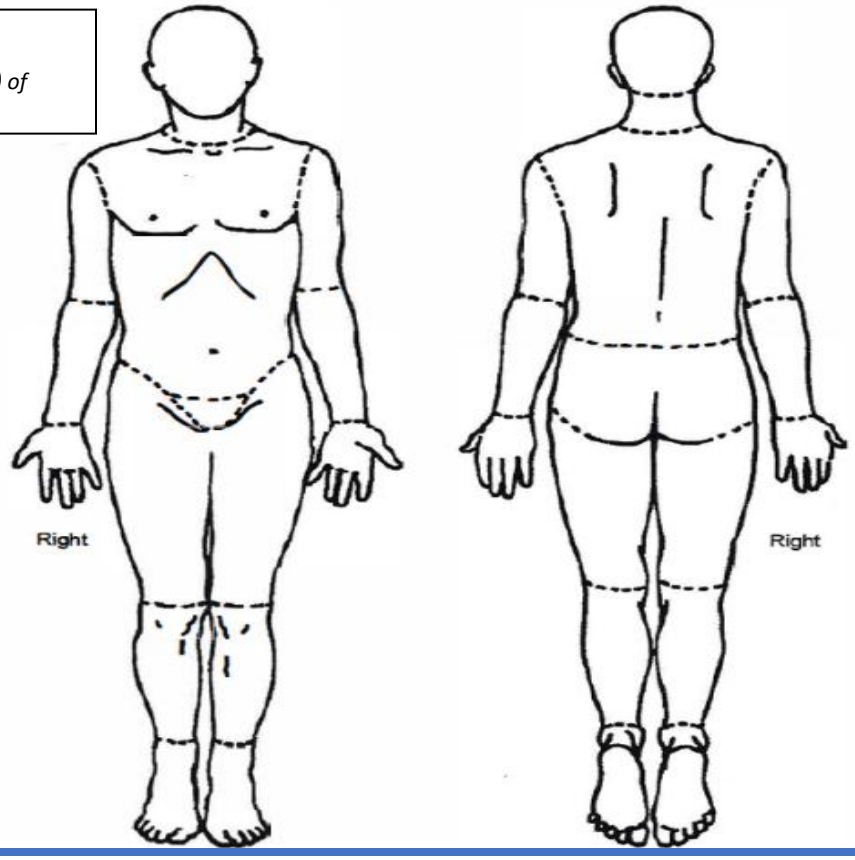
E) Associated Symptoms? (e.g swelling? Locking? Giving away, Tenderness, Fatigue, Bruising, Tingling, Numbness, Radiating Pain. Describe Where?)

_____
_____

F) What makes your symptoms better? ( e.g Rest, Heat, Cold, Elevation, Physical Therapy, Braces, Injections, Specia Positioning, Medications)

_____

**PAIN DRAWING**:
*place an x at the location(s) of your worst pain*




*Patient Statement:* To the best of knowledge, the above information is accurate and complete

Signed: _____ Date: _____

Physician signature: _____ Date: _____

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**PATIENT HISTORY** **DATE _____**

Past Hospitalization/ Surgeries/ Injuries and Approximate Dates: None: ( )

_____

_____

**Current Medical History** *Please circle Yes or No if you have any of the following medical problem?*

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| High Blood Pressure | Y | N | Diabetes | Y | N | Heart Trouble | Y | N |
| Respiratory Problems | Y | N | Stroke | Y | N | Cancer | Y | N |
| Bleeding Problems | Y | N | HIV/ AIDS | Y | N | | | |
| Pulmonary Embolism | Y | N | Blood Clot | Y | N | | | |
| Gastrointestinal Problems | Y | N | | | | | | |

Other Problems : _____

_____

| *Current Medications*: *NONE* ( ) MEDICATION NAME | DOSAGE | FREQUENCY |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

*Allergies*: ( ) None ( ) Contrast/ Dye ( ) Sulfa ( ) Penicillin ( ) Local Anesthetics ( ) Latex ( ) Iodine ( ) Shellfish Other: _____

Family History: *please list any FAMILY history medical problems ( e.g Heart Disease, Stroke, Diabetes, Cancer)*

Father:_____ Mother:_____

Siblings: _____ Other: _____

*Social History*

Marital Status: Single Married Separated Widowed Divorced Partner

Tobacco Use: Never Packs/ day_____ How many years? _____ Quit/ When: _____

Alcohol Use: Never Rarely Moderate Daily How Much? _____

Drug use: (prescription & non-prescription) Never Type & Frequency _____ Recovery Program? Y N

When? _____

*Highest level of education* ( ) High School ( ) College ( ) Trade School ( ) Graduate School ( ) Professional School

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**Review of Systems** Please circle Yes or No if you have any of the following problems

| | | | | | |
|---|---|---|---|---|---|
| Constitutional | | Ears / Nose/ Mouth/ Throat | | Eyes | |
| Good General Health | N Y | Hearing loss/ ringing | N Y | Wear glasses/ Contacts | N Y |
| Recent Weigh Change | N Y | Sinus Problems | N Y | Blurred/ double vision | N Y |
| Night Sweats, Fevers | N Y | Nose Bleeds | N Y | Eye Disease or Injury | N Y |
| Fatigue | N Y | Sore Throat/ Voice Change | N Y | Glaucoma | N Y |
| Cardiovascular | | Respiratory | | Gastrointestinal | |
| Chest Pain | N Y | Shortness of Breath | N Y | Nausea/ vomiting | N Y |
| Palpitations | N Y | Cough | N Y | Abdominal pain | |
| Heart Trouble | N Y | Wheezing/ Asthma | N Y | Rectal bleeding | N Y |
| Swelling hands/ feet | N Y | Coughing Blood | N Y | Bowel problems | N Y |
| Musculoskeletal | | Neurological | | Integumentary (skin/ breast) | |
| Muscle pain or cramps | N Y | Frequent Headaches | N Y | Change in hairs/ nails | N Y |
| Stiffness/ swelling joints | N Y | Paralysis or Tremors | N Y | Rashes or itching | N Y |
| Joint Pain | N Y | Convulsion/ seizures | N Y | Breast Lump | N Y |
| Trouble walking | N Y | Numbness/ tingling | N Y | Breast pain or discharge | N Y |
| Endocrine | | Hematologic/ Lymphatic | | Allergic/ Immunologic | |
| Excessive thirst/ urination | N Y | Bruise easily | N Y | Food allergies | N Y |
| Thyroid disease | N Y | Slow to heal | N Y | Aspirin Allergies | N Y |
| Hormone Problem | N Y | Enlarged glands | N Y | Antibiotic Allergies | N Y |
| Genitourinary- Male Only | | Genitourinary- Female Only | | Psychiatric | |
| Blood in urine | N Y | Blood in urine | N Y | Insomnia | N Y |
| Kidney Stone | N Y | Kidney Stone | N Y | Confusion/ memory loss | N Y |
| Sexual problems | N Y | Sexual problems | N Y | Depression | N Y |
| Testicular pain | N Y | Menstrual pain | N Y | | |