FORT WORTH ORTHOPEDICS

Medical History

Name:_____ **DOB:**_____ **Date:**_____

Primary Care Doctor: _____ **Who referred you?**_____

Chief Complaint: _____

When did the problem begin/surgery date: _____ **Which Side:** Right / Left

How did the pain begin: _____ **Does it wake you at night?** Yes or NO

Describe your pain/symptoms: (circle all that apply)

Sharp / Stabbing / Dull / Aching / Numb / Tingling / Burning / Pins & Needles / Popping / Locking Instability / Swelling / Limping / Constant / Intermittent Other:_____

What makes the pain worse: (Circle all that apply)

Walking / Standing / Sitting / Running / Twisting / Lifting / Bending / Overhead Activities / Reaching Back / Pivoting / Stairs / Getting up out of a chair / Car Rides / Sports Other:_____

What TREATMENT have you had for this problem? None / Tylenol / Advil (NSAIDs) / Steroids / ICE / HEAT / PT / Injections / Surgery / Chiropractic / Airrosti / Other:_____

Please list all medications, vitamins, OTC pain relievers, or any other substance taken on a regular basis:_____

Medical History: (Cont'd on back if needed)_____

Surgical History: _____

Drug, Tape or Dye Allergies:_____

Social History: Do you Smoke? (Please circle) Yes / Former Smoker / No, Never smoked

Are you Right or Left Handed? RIGHT or LEFT

Personal or Family History of Blood Clots? YES or NO **If yes, Explain:**_____

Do you have a medical history of MRSA or antibiotic resistance infection? YES or NO

If Yes, Explain:_____

If applicable:

1)Birth Control Medication(s) and Type:_____

2)Have you taken oral contraceptives within the past 3 months? YES or NO

3)Hormone replacement medication(s):_____

Work related injury: Worker's Compensation? YES or NO **Is there an attorney involved?** Yes or NO

Signature:_____ **Date:**_____

Patient/Guardian if Minor

STUDENT ATHLETES ONLY

Name of School you attend:_____

May we provide your athletic trainer and their associates with your health information? YES or NO