

Tracy Henderson, M.D
FORT WORTH ORTHOPEDICS

Height: _____

Weight: _____

Name: _____ DOB: _____ Date: _____

Race: _____

Ethnicity ☐ Hispanic or Latino ☐ Non-Hispanic or latino ☐ Decline to specify

Primary Care Doctor: _____ Who referred you? _____

Have you been seen by this provider's office within the last three years? Yes Or No

Chief Complaint: _____ Which Side: Right / Left

When did the problem begin/surgery date: _____

How did the pain begin: _____

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: _____

Have you had any IMAGING for this problem?(Circle all that apply) None/ X-ray/ MRI/ CT/ EMG

If yes, what facility was imaging done at? _____

Please list all medications, vitamins, OTC pain relievers, or any other substance taken on a regular basis: (write on back if needed) _____

Medical History: (write 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 **Does the pain wake you at night?** Yes or NO

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): _____

***Is this a WORK related injury? YES or NO**

***Is this an Auto/ Motorcycle accident? YES or NO**

***Is there an attorney involved? Yes or NO**

Signature: _____ Date: _____

Patient/Guardian if patient is a Minor

STUDENT ATHLETES ONLY

IS THIS A NEW INJURY OR REINJURY? (Circle one) DID YOU SEE A PROVIDER? YES / NO

Name of School you attend: _____

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