

**R. CHARLES MEDLAR, M.D.**

**ALLAN L. TOMPKINS, M.D.**

**PAUL S. KENYON, M.D.**

**JACKSON ORTHOPAEDICS AND SPORTS MEDICINE**

**PATIENT HISTORY FORM**

Note: This is a confidential record and will be kept in your doctor's office. Information here will not be released to anyone without your authorization to do so.

**Today's Date** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Last Name** \_\_\_\_\_ **First Name** \_\_\_\_\_ **Middle** \_\_\_\_\_

**Date of Birth** \_\_\_\_/\_\_\_\_/\_\_\_\_

**CHIEF COMPLAINT**

What is the main reason for your visit today? (Describe your problem in detail)

---

---

---

**DATE AND PLACE OF INJURY:**

**HISTORY OF PRESENT PROBLEM**

Please answer the following

Location of the problem:

---

---

---

Is anything else occurring at the same time?

Yes            NO    If yes, please explain

---

---

---

On a Scale of 1-10, with 10 being the most severe, circle the number that best describes the problem?

1 2 3 4 5 6 7 8 9 10

Is the problem constant or variable?

Dull then Sharp    Very Sharp then leaves    Always there  
Other \_\_\_\_\_

When did you first notice the problem? \_\_\_\_\_  
\_\_\_\_\_

Does anything help or make the problem worse?

Moving around    Standing Up    Lying on my side  
Other \_\_\_\_\_

Does the problem interfere with your normal functions?

Yes    NO    If Yes, please explain \_\_\_\_\_  
\_\_\_\_\_

How long does the problem last?

30 minutes    1 hour    It is always there  
Other \_\_\_\_\_

**RIGHT HANDED** \_\_\_\_\_

**LEFT HANDED** \_\_\_\_\_

#Answers	Level of Service
1 - 3	1 or 2
4+	3 - 5

## FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
<b>Father</b>			<b>Children</b>	<input type="checkbox"/> M	
<b>Mother</b>				<input type="checkbox"/> F	
<b>Sibling</b>	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F		<b>Grandmother</b> <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		<b>Grandfather</b> <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		<b>Grandmother</b> <i>Paternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		<b>Grandfather</b> <i>Paternal</i>		

## HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.					
<b>Exercise</b>	<input type="checkbox"/> Sedentary (No exercise)				
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
<b>Caffeine</b>	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea	<input type="checkbox"/> Cola	
	# of cups/cans per day?				
<b>Alcohol</b>	Do you drink alcohol?				<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, what kind?				
	How many drinks per week?				

<b>Tobacco</b>	Do you use tobacco?				
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day	<input type="checkbox"/> Cigars - #/day	
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit			
<b>Drugs</b>	Do you currently use recreational or street drugs?				
	Have you ever given yourself street drugs with a needle?				

Patient Surgeries		
Year	Reason	Hospital

Other hospitalizations		
Year	Reason	Hospital

<b>Have you ever had a blood transfusion?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
---	------------------------------	-----------------------------

Allergies to medications or other Allergies	
Name the Drug/Allergy	Reaction You Had

**Do you have a latex allergy?** \_\_\_No \_\_\_Yes

**IMMUNIZATIONS** (indicate year if known)

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Usual childhood imm. _____ | <input type="checkbox"/> Pneumonia vaccine _____ | <input type="checkbox"/> Tetanus _____ |
| <input type="checkbox"/> Hepatitis series _____     | <input type="checkbox"/> Flu Vaccine _____       | <input type="checkbox"/> Rubella _____ |

**REVIEW OF SYSTEMS:**

Check if you have, or have had, any symptoms in the following areas to a **significant degree** and briefly explain.

<input type="checkbox"/> Skin	<input type="checkbox"/> Chest/Heart	<input type="checkbox"/> Recent changes in: <input type="checkbox"/> Weight <input type="checkbox"/> Energy level <input type="checkbox"/> Ability to sleep <input type="checkbox"/> Other pain/discomfort:
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Back	
<input type="checkbox"/> Ears	<input type="checkbox"/> Intestinal	
<input type="checkbox"/> Nose	<input type="checkbox"/> Bladder	
<input type="checkbox"/> Throat	<input type="checkbox"/> Bowel	
<input type="checkbox"/> Lungs	<input type="checkbox"/> Circulation	

PATIENT'S MEDICAL HISTORY: List Significant events only

Yes	No		If YES, Please Explain Below
<input type="checkbox"/>	<input type="checkbox"/>	Asthma, Pneumonia	_____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes or low blood sugar	_____
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding, anemia	_____
<input type="checkbox"/>	<input type="checkbox"/>	Emotional or psychiatric disorders	_____
<input type="checkbox"/>	<input type="checkbox"/>	Chronic headache, pain, fainting	_____
<input type="checkbox"/>	<input type="checkbox"/>	Kidney or bladder problems	_____
<input type="checkbox"/>	<input type="checkbox"/>	Previous blood transfusions	_____
<input type="checkbox"/>	<input type="checkbox"/>	Seizures , strokes, convulsions	_____
<input type="checkbox"/>	<input type="checkbox"/>	Heart attack or heart problems	_____
<input type="checkbox"/>	<input type="checkbox"/>	Stomach ulcers or other UGI problems	_____

YES	NO		
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis, Liver problems	_____
<input type="checkbox"/>	<input type="checkbox"/>	High or Low blood pressure	_____
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	_____
<input type="checkbox"/>	<input type="checkbox"/>	Numbness of arms or legs	_____
<input type="checkbox"/>	<input type="checkbox"/>	Blood Clots	_____

YOUR MAIN HEALTH PROBLEMS ARE:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

If you have any questions about this form, or if there is other information which you have and which you feel might be important, please discuss it with the doctor.

Also, if any of the information which you have provided should change you should inform the doctor.

Signature: \_\_\_\_\_ Date \_\_\_\_\_

Physician use only: (Comments/Notes)

  
  
  
  
  
  
  
  
  
  

#Answer	Level of Service
0	1 or 2
1 - 2	3
3	4 or 5