St.Charles Orthopedics

INITIAL VISIT HISTORY FORM

Name:_____ Date:_____ Social Sec.# _____

Phone:_____ Age:_____ DOB:_____ Sex: M / F

Name of your Primary Care Doctor:_____

Were you referred by a physician? Y / N: Name: _____ Phone: _____

Reason for today's visit: (briefly state history of problem and when symptoms began)

_____

_____

Problem due to: (check) ____ car accident ____ work-related ____ school injury ____ other

Past Medical History: Have you ever had any of the following medical problems?

Yes	No		Yes	No		Yes	No	
__	__	Stroke	__	__	Cancer	__	__	Thyroid Disease
__	__	Ulcers	__	__	Hepatitis	__	__	Rheumatoid arthritis
__	__	Colitis	__	__	Diabetes	__	__	High Blood Pressure
__	__	Asthma	__	__	Tuberculosis	__	__	Nervous Disorder
__	__	Lyme Disease	__	__	Heart Disease	__	__	Bleeding Disorder
__	__	Arthritis	__	__	Kidney Stones	__	__	Endocrine problems

Explain any positive responses above (and other medical problems not listed): _____

_____

Past Surgical History: (list all surgeries) _____

_____

Medications (list): _____

_____

Allergies (medicines): _____

_____

Review of Systems: Are you having problems with any of the following?

Yes	No		Yes	No		Yes	No	
__	__	Eyes	__	__	Psychiatric problems	__	__	Digestion/Bowel Movement
__	__	Ears, nose, throat	__	__	Joint pain	__	__	Stomach burning
__	__	Lungs/breathing	__	__	Immune system	__	__	Cardiovascular problems
__	__	Recent weight loss	__	__	Urinary problems	__	__	Hematologic/bleeding problems
__	__	Weakness/fatigue	__	__	Chest pain	__	__	Neurologic problems

Explain positive responses: _____

_____

Family Medical History: List medical problems of your relatives (ex. Diabetes, cancer):

Grandparents:_____

Mother:_____ Father:_____

Siblings:_____

Children:_____

Social History: Occupation:_____ Working now? Yes / No / Retired

Do you smoke: Yes /No / Quit? Packs per day: ___ If Quit, years smoked: ___ yrs.

Alcohol use (circle one): Never / Occasional / Daily / Heavy / History of alcoholism

Any history of Drug use (list): _____

(circle one) Married / Single / Divorced / Widowed Live Alone? Yes / No

Are you on a special diet? _____

Do you exercise / play sports (describe briefly)? _____

Completed by: (sign)_____ Reviewed by: Dr. _____

Office Use Only ---------- H: _____ W: _____ T: _____

Revised 5/13