New West Sports Medicine & Orthopaedic Surgery, P.C. - Health History

Patient Name: _____ Date: _____ Chart #: _____

DOB: _____ Age: _____ Male / Female ☐ Left Handed ☐ Right Handed

Employer: _____ Job Title: _____

Pharmacy: _____ Location/City: _____

Family Physician: _____ Referring Provider: _____

History of Present Illness

Reason for visit: ☐ Right ☐ Left ☐ Bilateral

☐ ankle ☐ arm ☐ back ☐ clavicle ☐ elbow ☐ foot ☐ hand ☐ hip ☐ knee ☐ leg

☐ pelvis ☐ rib ☐ shoulder ☐ wrist ☐ neck ☐ other _____

Pain Scale (circle one number) No Pain 1 2 3 4 5 6 7 8 9 10 Severe Pain

Was this the result of an injury?

☐ No ☐ Work ☐ Auto ☐ Other Date of injury? _____

How and when did the problem start? _____

Past Medical History (please check all that apply)

☐ Alcoholism	☐ COPD	☐ Heart Disease	☐ Seizures
☐ Arthritis	☐ Depression	☐ High Blood Pressure	☐ Sleep Apnea
☐ Asthma	☐ Diabetes mellitus	☐ High Cholesterol	☐ Thyroid Disorder
☐ Bleeding Disorder	☐ Fibromyalgia	☐ Kidney Disease	☐ Wound Infection
☐ Blood Clot	☐ GERD (Acid Reflux)	☐ Osteoporosis	
☐ Cancer	☐ Gout	☐ Parkinson Disease	

Surgeries: (Please list all past surgeries. Indicate right or left if applicable and date if known.)

☐ None

R ☐ L ☐ _____	_____	R ☐ L ☐ _____	_____
R ☐ L ☐ _____	_____	R ☐ L ☐ _____	_____
R ☐ L ☐ _____	_____	R ☐ L ☐ _____	_____
R ☐ L ☐ _____	_____	R ☐ L ☐ _____	_____

Please complete back side of form **Please complete back side of form** **Please complete back side of form**

Allergies: (Please list)

☐ None

_____

_____

_____

Are you allergic to latex? ☐ Yes ☐ No

Medications: (Please list all prescription, non-prescription, birth control, and herbals)

If you have a list with you, we will photocopy

Generic/Brand Name of Prescription	Dosage (mg)	Generic/Brand Name of Prescription	Dosage (mg)
☐ None		_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family History

☐ Cancer ☐ Osteoporosis ☐ Kidney Disease

☐ Bleeding Tendency ☐ Heart Disease ☐ Stroke

☐ Diabetes ☐ High Blood Pressure ☐ Other_____

Have you or anyone in your family (mother, father, sister, brother) ever had a reaction to anesthetic, general or local, causing high fever (malignant hyperthermia), blood pressure problems, hepatitis or any other types of allergic reaction? **Yes**____ **No**____ **If yes, please explain:** _____

_____

Social History

☐ Smoking Tobacco Qty. /Day: _____ ☐ Alcohol Frequency: _____ ☐ Street Drug

☐ Vaping Qty. /Day: _____ ☐ None ☐ None

☐ Chewing Tobacco Qty./Day: _____

☐ None

Signature: _____ Date:_____