HISTORY FORM

Please complete thoughtfully each item of the following **MEDICAL HISTORY** and have it available to the physician when you are seen.

Patient Name: _____ Date of Evaluation: _____

Symptomatic Joint: Right ( ) Left ( ) Both ( )

I. PRESENT ILLNESS

	Please print answer	Physician's Comments
1. For what condition or symptoms are you being seen at this time?		
2. When did the accident occur, or symptoms/ condition first come upon you?		
3. History of Illness: In outline form: A) Give a list or step by step history of symptoms from onset to present. When possible, record the approximate date of important changes or developments.		
B) List other doctors seen for this condition and the approximate dates of their evaluation & treatment.		

II. PRESENT STATUS

Instructions: (Circle one which best describes your condition)

1. PAIN

A. None/Ignore
B. Slight, occasional, no compromise in activity
C. Mild, no effect on ordinary activity, pain after unusual activity, or use of aspirin or similar medication.
D. Moderate, tolerable, requires concessions in activity or occasional codeine or similar medication.
E. Severe, requiring limitation of activity.
F. Totally disabling.

2. FUNCTION

A. GAIT (walking maximum distance)

1) Limp:
None
Slight
Moderate
Severe
Unable to walk

2) Support:
None
Cane, long walks only
Cane, full time
One crutch
2 Canes
2 Crutches or walker
Unable to walk

3) Distance walked:
Unlimited
6 blocks
2-3 blocks
Indoor only
Bed & Chair

B. FUNCTIONAL ACTIVITIES

1) Stairs:
Normally (one step with one leg, next step with other leg)
Normally but with banister assistance
One step at a time
Not able

2) Socks/Tie shoes:

	Right	Left
	With ease	With ease
	With difficulty	With difficulty
	Unable	Unable

3) Cut toenails:

	Right	Left
	With ease	With ease
	With difficulty	With difficulty
	Unable	Unable

4) Sitting: Any chair for as long as needed
A high chair for only a limited amount of time
Unable to sit in any chair comfortably

5) Do you have night pain? Yes ( ) No ( )
Do you have pain while resting? Yes ( ) No ( )
Do you have pain on arising from sitting? Yes ( ) No ( )

III. PAST HISTORY

1. List all operations you have had	Date (approx)	Complications?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

2. Please list the date of other hospitalizations and reason for admission

DATE	REASON
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

3. Do you have or have you ever had…?

	YES	NO	WHEN/ONSET?
Heart Disease?	( )	( )	_____
Heart "Attack"?	( )	( )	_____
High Blood Pressure?	( )	( )	_____
Stroke?	( )	( )	_____
Irregular Heartbeats?	( )	( )	_____
Easy Bruising?	( )	( )	_____
Anemia (Low blood count)?	( )	( )	_____
Phlebitis (Clots in leg veins)?	( )	( )	_____
Blood Disorders?	( )	( )	_____
Pulmonary Embolus (Blood clot to lungs)?	( )	( )	_____
Nerve Paralysis?	( )	( )	_____
Fainting Spells?	( )	( )	_____
Epilepsy (Seizures)?	( )	( )	_____
Other Nervous System Disease?	( )	( )	_____
Skin Disorders?	( )	( )	_____
Thyroid Disease?	( )	( )	_____
Diabetes?	( )	( )	_____
Glaucoma?	( )	( )	_____
Emphysema?	( )	( )	_____
Tuberculosis?	( )	( )	_____
Drug Addiction?	( )	( )	_____
Sinus Disease?	( )	( )	_____
Stomach Ulcers?	( )	( )	_____
Cirrhosis?	( )	( )	_____
Hepatitis?	( )	( )	_____
Gallstones?	( )	( )	_____
Kidney Disease (Chronic Urine Infections, Prostatitis)?	( )	( )	_____
Cancer?	( )	( )	_____

4. What is the condition of your teeth? Good ( ) Need repair/extraction ( )

5. Medications: Please list the names & doses of any medicines you now take or have taken within the last six months.

NAME	DOSE	NAME	DOSE
_____		_____	
_____		_____	
_____		_____	
_____		_____	
_____		_____	
_____		_____	

	YES	NO	
6.	( )	( )	Have you ever taken Cortisone or Prednisone by mouth or by injection?
7.	( )	( )	Are you allergic to any medicine, metals, tape, Iodine? Please list:_____
			_____
8.	( )	( )	Do you drink alcohol? If yes, How many days a week? _____ How many drinks per day? _____
9.	( )	( )	Do you smoke? If yes, How many cigarettes a day? _____ If you used to smoke, how many years did you smoke? _____ How many packs a day? _____
10.	( )	( )	Do you drink coffee? How much per day? _____
11.			Approximate date of last physical examination? _____

IV. REVIEW OF SYSTEMS

Place a check mark next to the appropriate items in the following list if you are presently experiencing that symptom.

1. HEAD & NECK	YES	NO		YES	NO
Severe headache?	( )	( )	Toothache?	( )	( )
Dizzy spells?	( )	( )	Sinus infection/obstruction	( )	( )
Failing vision?	( )	( )	Persistent sore gums?	( )	( )
Severe hearing loss?	( )	( )	Prolonged hoarseness?	( )	( )
Ringing in ears?	( )	( )	Persistent neck stiffness?	( )	( )
Discharge from ears?	( )	( )	Swelling in neck?	( )	( )

2. HEART, LUNGS, & CIRCULATION

	YES	NO		YES	NO
Chest pain on effort?	( )	( )	Varicose veins?	( )	( )
Skipping heartbeats?	( )	( )	Poor leg circulation?	( )	( )
Difficult breathing?	( )	( )	Cramps with walking?	( )	( )
Sit up to breathe easy?	( )	( )	Night sweats?	( )	( )
Chronic cough?	( )	( )	Ankle swelling?	( )	( )
Spit up blood?	( )	( )			

3. STOMACH & INTESTINES

Chronic stomach pain?	( )	( )	Skin turn yellow?	( )	( )
Persistent nausea?	( )	( )	Any black tarry stool?	( )	( )
Heart burn?	( )	( )	Change in bowel habits?	( )	( )
Appetite loss?	( )	( )	Hernia?	( )	( )
Increased thirst?	( )	( )	Any blood from rectum?	( )	( )
Weight gain?	( )	( )	Clay colored stools?	( )	( )
Weight loss?	( )	( )	Habitual constipation?	( )	( )
Vomit blood?	( )	( )			

4. URINARY TRACT

Scanty urination	( )	( )	Passed stones?	( )	( )
Blood in urine?	( )	( )	Retention of urine?	( )	( )
Urinate at night?	( )	( )	Men only-Scrotal swelling?	( )	( )
Pain with urination?	( )	( )	Women-Breast pain/lumps?	( )	( )
Any leakage of urine?	( )	( )	Women-Abnormal menses?	( )	( )

5. MUSCLE-JOINTS-NERVES

Tingling sensation?	( )	( )	Alcohol problem?	( )	( )
Numbness?	( )	( )	Drug problem?	( )	( )
Disturbance in walking?	( )	( )	Mental problem?	( )	( )
Muscle jerking?	( )	( )	Ruptured disc or sciatica?	( )	( )
Paralysis?	( )	( )	Spinal curvature?	( )	( )
Shaking?	( )	( )	Brittle or soft bones?	( )	( )
Depression, severe tension?	( )	( )	Speech disturbance?	( )	( )
Nervous breakdown?	( )	( )	Inherited or congenital		
Personality changes?	( )	( )	abnormality of extremities?	( )	( )

V. FAMILY HISTORY

	Age now or at time Of Death (Indicate D)	Medical Conditions including Cause of death, if deceased
Father	_____	_____
Mother	_____	_____
Brothers	_____	_____
Sisters	_____	_____

YES	NO	Has anyone in your family:	Who?
( )	( )	Had a tendency to bleed excessively?	_____
( )	( )	Had unusual reactions to anesthesia?	_____
( )	( )	Had unexplained fevers during or following a surgery?	_____
( )	( )	Had tuberculosis?	_____
( )	( )	Had arthritis?	_____
( )	( )	Had hypertension?	_____
( )	( )	Had cancer?	_____
( )	( )	Had diabetes mellitus?	_____
( )	( )	Had hip dislocations?	_____

VI. PERSONAL HISTORY

Place of birth: _____

What is the highest level of education you have obtained? _____

Marital Status: Single ( ) Married ( ) Separated ( ) Divorced ( ) Widowed ( )

What is your current occupation? _____

Do you live in a ( ) Private home ( ) Apartment ( ) Other _____

Is your home ( ) Single level ( ) Multi level

With whom do you live? _____

Do you require attendant help? _____

Do you have any children? ( ) Yes ( ) No How many? _____

HIP PATIENT SUPPLEMENT

	YES	NO
If present, where is your pain located?		
Front of hip or groin?	( )	( )
On the side of hip?	( )	( )
Buttock or back of hip?	( )	( )
Does the pain go down the leg?	( )	( )
If yes, how far? _____		
Front or back of leg? _____		
Do you have or have you had a problem with low back pain?	( )	( )
Have you had back surgery?	( )	( )
Do you use a lift on your shoe?	( )	( )
Does your hip feel worse after a little walking?	( )	( )
Did you have a problem with your hip in childhood?	( )	( )
Do you require the assistance of your arms or somebody? Helping you get out of a chair?	( )	( )
Are you unable to work because of your hip problem?	( )	( )
If yes, will you return to work if the hip problem is corrected?	( )	( )
Do you require medication to relieve the pain?	( )	( )
If yes, please list: _____		
Does your hip condition prevent exercise or sport activities?	( )	( )
If yes, list exercise or sport unable to perform _____		
Have you given up any of the following activities because of your Hip problem?		
Gardening?	( )	( )
Travel?	( )	( )
Home maintenance or cleaning?	( )	( )
Sports Activity?	( )	( )
Other, please list _____		