

# HISTORY FORM

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

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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?

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2. When did the accident occur, or symptoms/condition first come upon you?

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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.

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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:                       | <u>Right</u><br>With ease<br>With difficulty<br>Unable  | <u>Left</u><br>With ease<br>With difficulty<br>Unable |
| 3) Cut toenails:                          | <u>Right</u><br>With ease<br>With difficulty<br>Unable  | <u>Left</u><br>With ease<br>With difficulty<br>Unable |
| 4) Sitting:                               | Any chair for as long as needed<br>A high chair for only a limited amount of time<br>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.	<u>HEAD &amp; NECK</u>	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

	<b>YES</b>	<b>NO</b>		<b>YES</b>	<b>NO</b>
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	_____	_____

<b><u>YES</u></b>	<b><u>NO</u></b>	<b><u>Has anyone in your family:</u></b>	<b><u>Who?</u></b>
( )	( )	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

	<u>YES</u>	<u>NO</u>
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 _____		