WEST MICHIGAN ORTHOPAEDICS

PATIENT HEALTH HISTORY

PATIENT _____ **DATE OF BIRTH** _____ **HEIGHT** _____ **WEIGHT** _____

MEDICATION & SURGERY HISTORY

Drug Allergies _____
Current Medications _____
_____
Pharmacy (name/address/phone) _____
Previous Surgery(s) _____
_____

NATURE OF PROBLEM/INJURY

Chief Complaint _____
When did problem/injury first occur? _____
What treatment have you had? _____
Have you seen another physician for this problem? ❑ Yes ❑ No If yes, name(s): _____

MEDICAL PROBLEMS

Have you had or do you currently have any of the following? *If none, check here:* ❑

___ High blood pressure	___ Thyroid disorder	___ HIV / Hepatitis infection
___ Heart disease	___ Respiratory / lung disorder	___ Stroke
___ Diabetes	___ Cancer	___ Other _____

REVIEW OF SYSTEMS

Have you had or do you currently have any of the following? *If none, check here:* ❑

___ Arthritis	___ Fevers	___ Unexplained weight loss
___ Chest pain	___ Recent infection	___ History of steroid (prednisone) use
___ Shortness of breath	___ History of blood clots	___ Environmental allergies
___ Asthma	___ Bleeding problems	___ Excessive fatigue/weakness
___ Heartburn/ulcers	___ Anesthesia problems	___ Limited exercise/walking tolerance
___ Skin rash/dermatitis	___ Severe headaches/migraines	___ Other_____

SOCIAL HISTORY

Marital status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed
Housing status: ❑ Live alone ❑ Live with spouse/partner ❑ Live in nursing/assisted care facility
❑ Other _____
Do you use tobacco? ❑ Yes ❑ No If yes, type and how much? _____
Do you consume alcoholic beverages? ❑ Yes ❑ No If yes, average drinks per day? _____
Occupation: _____

FAMILY HISTORY

Do you have a family history of any of the following? *If none, check here:* ❑

___ Heart problems	___ Stroke
___ High blood pressure	___ Cancer
___ Diabetes	___ Other_____

OSTEOPOROSIS SCREENING

Results of a previous bone density scan: ❑ Never tested ❑ Normal ❑ Low
Have you ever broken a bone? ❑ Yes ❑ No If yes, which bone(s) _____
Daily calcium intake (type/dose) _____
Do you have a family history of broken bones/osteoporosis? ❑ Yes ❑ No

For Office Use Only

Patient Signature _____ **Date** _____

(REV 05/15)

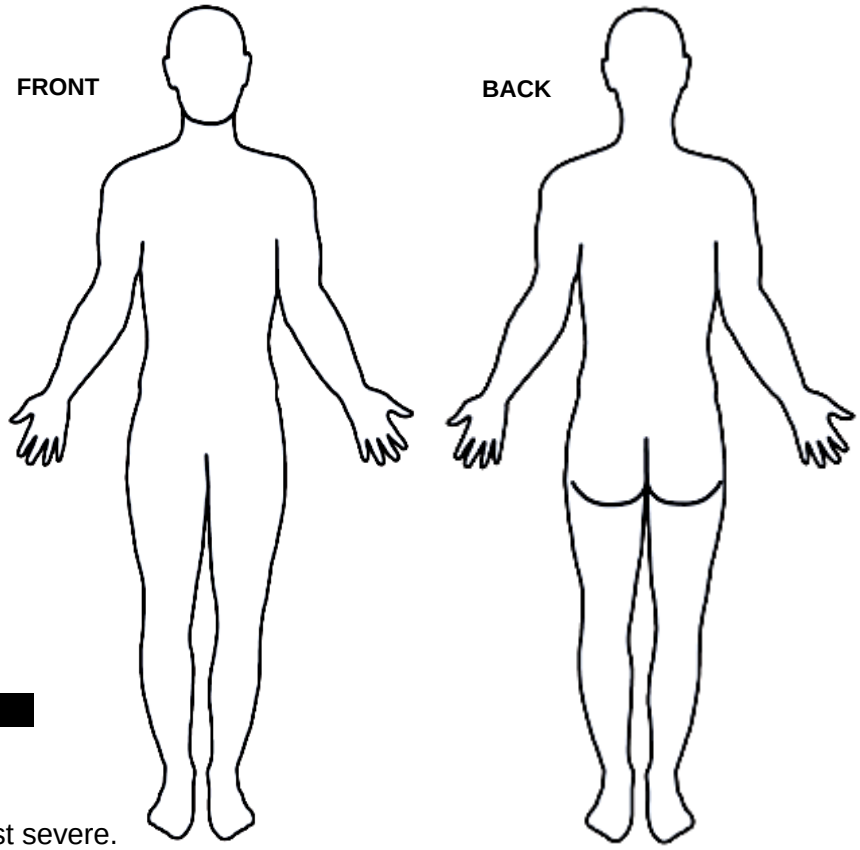
WEST MICHIGAN ORTHOPAEDICS

PAIN ASSESSMENT

PATIENT _____ **DATE OF BIRTH** _____

PAIN DIAGRAM

Using the symbols below, mark the areas on your body where you feel the described sensation. Include all affected areas.



SYMBOLS:

Dull, Achy
///
Sharp, Stabbing
XXX
Electrical, Shooting
≈≈≈

PAIN SCALE

(0 = No Pain and 10 = Worst Pain Imaginable)

Circle the **range** of your pain from best to most severe.

0 1 2 3 4 5 6 7 8 9 10

Circle your **current level** of pain.

0 1 2 3 4 5 6 7 8 9 10

TREATMENT

What makes your pain **better**? _____

What makes your pain **worse**? _____

Have you tried:

- **Pain medication**? ❑ Y ❑ N
  If yes, which one? _____
- **Physical therapy**? ❑ Y ❑ N
  If yes, where and for how long? _____
- **Injection**? ❑ Y ❑ N
  If yes, when? _____ Was it temporarily helpful? _____