Saint Francis HEALTHCARE | Advanced Orthopedic Specialists

48 Doctors Park
Cape Girardeau, Missouri 63703
P 573-335-8257
TF 800-321-3167
Other Locations
Jackson | Poplar Bluff | Sikeston

Patient History Form

Name: _____ Date of Birth: _____ Age: _____
Height: _____ Weight: _____ Are you: ☐ Right / ☐ Left handed? (Please select one)
Where is the pain or problem located? _____
Is the problem on the ☐ Right or ☐ Left (Please select one)
Date of injury/Onset of pain: _____ Result of an auto accident? ☐Y ☐N
Is this a work related injury? ☐Y ☐N Did you file a Worker's Comp Claim? ☐ Y ☐ N
Did you notify your employer? ☐ Y ☐N Are you still working? ☐Y ☐N If no, your last day of work: _____
If other type of accident/injury, please describe _____

Primary Physician: _____ Referring Physician or Source: _____
Have you had any testing or imaging done for this problem, and if so where? _____

Preferred Pharmacy _____
City _____ State _____ Zip _____

Medical History: *Do you have or have you had any of the following?*

☐ None

YES
- ☐ Angina / Chest Pain
- ☐ Heart Attack / MI
- ☐ Blood Bleeding Disorder / Anemia
- ☐ Blood Transfusion
- ☐ Lung Disease / COPD
- ☐ Tuberculosis
- ☐ Stroke
- ☐ Kidney / Bladder /Prostrate
- ☐ Diabetes
- ☐ Osteoarthritis
- ☐ Alcoholism
- ☐ HIV or AIDS
- ☐ Cancer if yes, type and date of diagnosis: _____

YES
- ☐ High Blood Pressure
- ☐ Heart Valve Disease
- ☐ Blood Clots / Phlebitis
- ☐ Hemophilia
- ☐ Asthma
- ☐ Epilepsy / Seizure Disorder
- ☐ Parkinson's Disease
- ☐ Hepatitis
- ☐ Gout
- ☐ Polio
- ☐ Drug Addiction

- ☐ High Cholesterol
- ☐ Heart Rhythm Problem
- ☐ Peripheral Vascular Disease
- ☐ Sickle Cell Disease
- ☐ Emphysema
- ☐ Migraine Headaches
- ☐ Thyroid Problem hyper / hypo
- ☐ Lupus
- ☐ Rheumatoid Arthritis
- ☐ Stomach Ulcers
- ☐ Psychiatric Problems

Other Medical Conditions: _____

Family History: *Please check any problems that run in your family:*

☐ None

YES
- ☐ Heart Attack
- ☐ Bleeding Problems
- ☐ Stroke
- ☐ Cancer if yes, what type: _____
- ☐ Other: _____

YES
- ☐ Heart Trouble
- ☐ Lung Disease
- ☐ High Blood Pressure

YES
- ☐ Asthma
- ☐ Arthritis
- ☐ Alcoholism

YES
- ☐ Diabetes
- ☐ Gout
- ☐ Mental Illness

Orthopedic Surgeries: *Please list any orthopedic surgeries you have had and the dates of surgery:*

☐ None

_____ _____

_____ _____

_____ _____

_____ _____

Other Surgeries or Hospitalizations: *Please list any other surgeries or hospitalizations and the dates:*

☐ None

☐ Childbirth _____ ☐ Stroke _____

☐ Heart Attack _____ ☐ Appendectomy _____

☐ Tonsillectomy _____ ☐ Gall Bladder _____

☐ Hysterectomy _____ ☐ Other _____

☐ Other _____ ☐ Other _____

☐ Other _____ ☐ Other _____

Medications: *Please list all medications and supplements you take both prescription and over the counter:*

☐ None

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Allergies: *Please list all medications, food, or substances you are allergic to and the nature of your restriction, rash, swelling, difficulty breathing, nausea, or other:*

☐ None

	Rash	Swelling	Trouble Breathing	Nausea	Other
☐ Penicillin	☐	☐	☐	☐	☐ _____
☐ Sulfa	☐	☐	☐	☐	☐ _____
☐ Codeine	☐	☐	☐	☐	☐ _____
☐ Aspirin	☐	☐	☐	☐	☐ _____
☐ Morphine	☐	☐	☐	☐	☐ _____
☐ Adhesive Tape	☐	☐	☐	☐	☐ _____
☐ Tetanus	☐	☐	☐	☐	☐ _____
☐ Iodine	☐	☐	☐	☐	☐ _____
☐ Dyes	☐	☐	☐	☐	☐ _____
☐ Arthritis Medicine	☐	☐	☐	☐	☐ _____

☐ Antibiotics: *Please List:* _____

☐ Other: *Please List:* _____

Social History:

Work Status ☐ Working ☐ Unemployed ☐ Disabled ☐ Retired ☐ Homemaker

Occupation: _____

Do you live alone? ☐ Y ☐ N If no, who do you live with: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Tobacco Use: ☐ Never ☐ Cigar ☐ Chew ☐ Pipe

☐ Cigarettes: Packs per day? _____ Years: _____

☐ Quit Smoking _____ years ago, after smoking _____ packs per day for _____

Alcohol: ☐ Never ☐ Rare ☐ Occasional ☐ Social amount per day /week: _____

Drug Abuse: ☐ Never ☐ In the past ☐ Currently

Review of Systems: *Please select any condition you are currently experiencing:*

Constitution ☐ None
- ☐ Activity change
- ☐ Appetite change
- ☐ Chills
- ☐ Diaphoresis
- ☐ Fatigue
- ☐ Fever
- ☐ Unexpctd wt chnge

HENT ☐ None
- ☐ Congestion
- ☐ Dental problem
- ☐ Drooling
- ☐ Ear discharge
- ☐ Ear pain
- ☐ Facial swelling
- ☐ Hearing loss
- ☐ Mouth sores
- ☐ Nosebleeds
- ☐ Postnasal drip
- ☐ Rhinorrhea
- ☐ Sinus Pain
- ☐ Sinus Pressure
- ☐ Sneezing
- ☐ Sore throat
- ☐ Tinnitus
- ☐ Trouble swallowing
- ☐ Voice change

Eyes ☐ None
- ☐ Eye discharge
- ☐ Eye itching
- ☐ Eye pain
- ☐ Eye redness
- ☐ Photophobia
- ☐ Visual disturbance

Respiratory ☐ None
- ☐ Apnea
- ☐ Chest tightness
- ☐ Choking
- ☐ Cough
- ☐ Shortness of breath
- ☐ Stridor
- ☐ Wheezing

Cardio ☐ None
- ☐ Chest pain
- ☐ Leg swelling
- ☐ Palpitations

GI ☐ None
- ☐ Abd distention
- ☐ Abdominal pain
- ☐ Anal bleeding
- ☐ Blood in stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Rectal pain
- ☐ Vomiting

Endocrine ☐ None
- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Polydipsia
- ☐ Polyphagia
- ☐ Polyuria

GU ☐ None
- ☐ Difficulty utinating
- ☐ Dyspareunia
- ☐ Dysuria
- ☐ Enuresis
- ☐ Flank pain
- ☐ Frequency
- ☐ Genital sore
- ☐ Hematuria
- ☐ Menstrual problem
- ☐ Pelvic Pain
- ☐ Urgency
- ☐ Urine decreased
- ☐ Vaginal bleeding
- ☐ Vaginal discharge
- ☐ Vaginal pain

MUSC ☐ None
- ☐ Arthralgias
- ☐ Back pain
- ☐ Gait problem
- ☐ Joint swelling
- ☐ Myalgias
- ☐ Neck pain
- ☐ Neck stiffness

Skin ☐ None
- ☐ Color change
- ☐ Pallor
- ☐ Rash
- ☐ Wound

Allerg/Immuno ☐ None
- ☐ Env allergies
- ☐ Food allergies
- ☐ Immunocompromised

Neurological ☐ None
- ☐ Dizziness
- ☐ Facial asymmetry
- ☐ Headaches
- ☐ Light-headeness
- ☐ Numbness
- ☐ Seizures
- ☐ Speech difficulty
- ☐ Syncope
- ☐ Tremors
- ☐ Weakness

Hematologic ☐ None
- ☐ Adenopathy
- ☐ Bruises/blds easily

Psychiatric ☐ None
- ☐ Agitation
- ☐ Behavior problem
- ☐ Confusion
- ☐ Decr concentration
- ☐ Dysphoric mood
- ☐ Hallucinations
- ☐ Hyperactive
- ☐ Nervous/anxious
- ☐ Self-injury
- ☐ Sleep disturbance
- ☐ Suicidal ideas

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____