AZALEA ORTHOPEDICS
PATIENT HISTORY

Name:	Age:	DOB:	Sex:	ID:
Occupation:				
Hand Dominance: RT _____ LT_____				
Referring MD:				
HISTORY OF PRESENT ILLNESS / INJURY (REASON FOR YOUR VISIT)				
Reason for Visit:				
Date of Onset (WHEN DID IT HAPPEN):				
Mechanism of Injury: (HOW DID IT HAPPEN):				
Is this work related? YES NO				
DESCRIPTION OF PAIN				
LOCATION:				
TYPE: Shooting Throbbing Sharp Burning Aching Tenderness				
DURATION: Constant Frequent Sometimes				
SYMPTOMS: Swelling Bruising Numbness Tingling Grinding Popping				
What makes it better?				
What makes it worse?				
PRIOR TREATMENT FOR THIS PROBLEM (INCLUDE DATES)				
Physician / Hospital:				
Medication / Injections:				
Physical Therapy:				
Diagnostic Tests:				
HAS PATIENT MISSED WORK FOR CURRENT PROBLEM? YES NO				
IF YES, LAST DAY WORKED: _____ / _____ / _____				
PRESENT MEDICATIONS (PLEASE LIST ALL)				
DATE OF LAST:				
COLONOSCOPY?				
FLU SHOT?				
PNEUMONIA SHOT?				

ALLERGIES

Medication / Food Allergies?	YES	NO	OTHER:
Allergic to Nickel?	YES	NO	
Reaction?			

PAST SURGERIES AND DATES

SOCIAL HISTORY

Alcohol	Never	Social	Frequent	Type?	Quit? / When?
Drug Use	Never	Occasional	Frequent	Type?	Quit? / When?
Exercise	None	Occasional	Moderate	Heavy	
Marital Status	Single	Married	Divorced	Widowed	
Tobacco	Never	Packs / Day		Smokeless	Quit? / When?
Military	Active	Inactive	None		

IMMEDIATE FAMILY MEDICAL HISTORY

(Please specify relation) (Circle all that apply)

High Blood Pressure	YES	NO	HIV / AIDS	YES	NO
Respiratory Problems	YES	NO	Heart Trouble	YES	NO
Bleeding Problems	YES	NO	Cancer	YES	NO
Diabetes	YES	NO	Other Problems	YES	NO
Stroke	YES	NO			

PATIENT MEDICAL HISTORY

(Circle all that apply)

Abdominal Problems	YES	NO	Hepatitis	YES	NO
Anesthesia Problems	YES	NO	HIV / AIDS	YES	NO
Asthma	YES	NO	Hormone Abnormalities	YES	NO
Bleeding Problems	YES	NO	Hypertension	YES	NO
Blood Clots	YES	NO	Kidney Stones / Disease	YES	NO
Bowel Problems	YES	NO	Lung Disease	YES	NO
Breast Lumps / Pain	YES	NO	Menstrual Problems	YES	NO
Bronchitis	YES	NO	Muscle Disease	YES	NO
Cancer	YES	NO	Neurologic Disease	YES	NO
Cataracts	YES	NO	Psychiatric Disease	YES	NO
Convulsions / Seizures	YES	NO	STD	YES	NO
Coronary Artery Disease	YES	NO	Stroke	YES	NO
Depression	YES	NO	TB	YES	NO
Diabetes	YES	NO	Trouble Walking	YES	NO
Esophagitis	YES	NO	Thyroid Disease	YES	NO
Eye Disease / Glaucoma	YES	NO	Weight Change	YES	NO
Gerd	YES	NO	Wound Healing Issues	YES	NO
GI	YES	NO			
Good General Health	YES	NO			
Heart Disease	YES	NO			

REVIEW OF SYSTEMS

Do you have or have you had any of the following?

Constitutional:

Fever	Yes	No

Eyes:

Double Vision	Yes	No

ENMT:

Hearing Loss	Yes	No

Respiratory:

Shortness of Breath	Yes	No

Gastrointestinal:

Nausea	Yes	No
Vomiting	Yes	No

Skin:

Rash	Yes	No

Musculoskeletal:

Limited Motion	Yes	No
Joint Pain	Yes	No

Neurological:

Numbness / Tingling	Yes	No

Cardiovascular:

Swelling	Yes	No

Hematologic:

Blood Clot	Yes	No