SIERRA PACIFIC ORTHOPAEDIC & SPINE CENTER
MEDICAL GROUP, INC.

PATIENT HISTORY FORM

Name: _____ Today's Date: _____
Age: ____ Occupation: _____ ❑Right-handed ❑Left-handed
Height:_____ Weight:_____

History of Current Problem

What body part is involved?_____ Left/Right/Both(circle)

When did your problem start?_____

How did the injury/problem start? _____

_____

Where did the problem occur? _____

What treatment have you already had? _____

Were you injured at work? ❑ Yes ❑ No
Are you currently working? ❑ Regular work ❑ Modified work ❑ Not working

Past Medical History Do you have a history of the following problems?

❑ High blood pressure	❑ Asthma	❑ Emphysema or COPD
❑ Heart Arrhythmia	❑ Diabetes	❑ Ulcers
❑ Coronary artery disease or heart attacks	❑ Liver disorder	❑ TB
	❑ Rheumatoid arthritis	❑ Arthritis
❑ Cancer (type):_____	❑ Deep vein thrombus	❑ Polio
❑ Seizures/Epilepsy	❑ Bleeding disorder	❑ Problems with anesthesia
❑ Alcohol use	❑ Tobacco use	❑ Recreational drugs
❑ Sleep Apnea	❑ Claustrophobia	❑ Other

Surgeries/Hospitalizations	Year	Complications

Medications Please list all medications that you currently are taking.

Medication(s)	Dose	Reason for Medication

Over

Revised 8/2/2004

Name: _____ Today's Date: _____

ALLERGIES: **Latex** ❑ **Yes** ❑ **No**
Iodine ❑ **Yes** ❑ **No**
Other _____
_____
_____

❑ **None Known**

Social History

Marital status	❑ Single	❑ Married	❑ Divorced	❑ Widowed
Do you exercise?	❑ Daily	❑ Weekly	❑ Monthly	❑ Never
Smoke	❑ Yes	❑ Quit	❑ Never	How much? _____
Alcohol	❑ Yes	❑ Quit	❑ Never	How often? _____

Do you have a Durable Power of Attorney? ❑ Yes ❑ No

Family History

Member	Alive	Deceased	Age	Health status or cause of death
Father	❑	❑	____	_____
Mother	❑	❑	____	_____
Sister/brother	❑	❑	____	_____
Sister/brother	❑	❑	____	_____
Sister/brother	❑	❑	____	_____
Children	❑	❑	____	_____
Children	❑	❑	____	_____
Children	❑	❑		

Review of Systems

Are you currently having problems with any of the following:

	Yes	No	Describe all Yes responses
Eyes	❑	❑	_____
Ears, nose, throat	❑	❑	_____
Heart	❑	❑	_____
Lungs, breathing	❑	❑	_____
Digestion/bowels	❑	❑	_____
Bladder	❑	❑	_____
Bleeding problems	❑	❑	_____
Balance problems	❑	❑	_____
Blackout/fainting	❑	❑	_____
Numbness/tingling	❑	❑	_____
Psychological problems	❑	❑	_____
Weight Loss	❑	❑	_____
Fevers	❑	❑	_____
Osteoporosis	❑	❑	_____

Have you ever had your bone density tested? ❑ Yes ❑ No When_____ Where_____

Patient signature: _____ **Date:** _____

Physician signature: _____ **Date:** _____

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