Today's Date:

Texas Orthopedic Partners

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New Orthopedic Surgery Patient Medical History Form

Patient Name: DOB:

Problem History and Background

Please indicate your current pain level

0 1 2 3 4 5 6 7 8 9 10

What words best describe how the pain feels?

Sharp Burning Shooting Deep

Stabbing Throbbing Aching Pressure

Dull Tingling Other_____

Constitutional

hills

Weight Loss

Malaise/Fatigue

Diaphoresis (Excessive Sweating)

Weakness

Skin

Rash

Itching

HENT

Headaches

Hearing Loss

Tinnitus

Ear Pain

Ear Discharge

Nosebleeds

Congestion

Stridor– (Vibrating Noise when breathing)

Sore Throat

Eyes

Blurred Vision

Double Vision

Photophobia (Sensitivity to light)

Eye Pain

Eye Discharge

Eye Redness

Cardiovascular

Chest Pain

Palpitations

Orthopnea

Claudication (cramping pain caused by obstruction in arteries)

Leg Swelling

PND– attacks of shortness of breath and coughing at night)

Respiratory

Hemoptysis-(Coughing up blood)

Sputum Production– (Excessive mucus)

Shortness of Breath

Wheezing

Gastrointestinal

Heartburn

Nausea

Vomiting

Abdominal Pain

Diarrhea

Constipation

Blood in Stool

Melena– (Dark, Sticky stool)

Genitourinary

Dysuria– (Painful urination)

Urgency

Frequency

Hematuria– (Blood in urine)

Flank Pain

Musculoskeletal

Myalgias- (Muscle pain)

Neck Pain

Back Pain

Joint Pain

Falls

Endo/Hem/Aller

Easy Bruise/bleed

Environmental Allergies

Polydipsia-(Great feeling of thirst)

Neurological

Dizziness

Tingling

Tremor

Sensory Change

Speech Change

Focal Weakness

Seizures

LOC– (Loss of Consciousness)

Psychiatric

Depression

Suicidal Ideas

Substance Abuse

Hallucinations

Nervous/Anxious

Insomnia

Memory Loss

I attest that everything stated here is true to the best of my knowledge:

Patient Signature: **Date:**

I have personally reviewed this form with the patient:

Physician Signature: **Date:**