PATIENT HISTORY FORM 1

Southwest Joint Replacement & Sports Medicine Center		
Patient Name	Date of Birth (MM/DD/YYYY)	Today's Date (MM/DD/YYYY)

Height _____ Weight _____

Primary Care Doctor Name, Address & Tel #_____

Referring Provider Name, Address & Tel #_____

Pharmacy Name & Address: _____ Pharmacy #: _____

HISTORY OF PRESENT ILLNESS

What is the main reason for your visit today: _____

_____

Please indicate the pain level of your current problem (0 being the lowest & 10 being the highest) 0☐1☐2☐3☐4☐5☐6☐7☐8☐9☐10☐

When did this problem begin: _____ (Please specify date)

Is this problem due to an injury? ☐YES ☐NO If yes, what is the date of injury? _____

DID THE INJURY OCCUR AT WORK? ☐YES ☐NO **IF YES STOP AND NOTIFY THE FRONT DESK. OUR DOCTORS DO NOT TREAT WORK INJURIES.**

IS THIS INJURY DUE TO AN AUTO ACCIDENT? ☐YES ☐NO **(THIS PRACTICE DOES NOT ACCEPT LETTERS OF PROTECTION)**

For this injury/problem have you recently had an: X-Ray? ☐YES ☐NO MRI? ☐YES ☐NO CT? ☐YES ☐NO

If yes, when & where?_____ What treatment have you received?_____

Which hand is your dominant? ☐Right ☐Left Are you pregnant? ☐YES ☐NO If yes, when is your due date? _____

MEDICATIONS, VITAMINS & SUPPLEMENTS

Please list the name, dosage and frequency of the Medication, Vitamin and/or Supplement

_____ _____ _____

_____ _____ _____

_____ _____ _____

PAST MEDICAL HISTORY

☐ **Check this box and skip this section if you recently completed the portal questionnaire**

HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING: ANSWER EACH WITH YES/NO AS APPLIES

☐Y/☐N Anemia or Bleeding Problems	☐Y/☐N Cancer	☐Y/☐N Heart Attack	☐Y/☐N High Cholesterol	☐Y/☐N Stroke
☐Y/☐N Blood Clots	☐Y/☐N Chest Pain	☐Y/☐N Heart Disease	☐Y/☐N Hypertension	☐Y/☐N Ulcer
☐Y/☐N Blood Transfusion	☐Y/☐N Diabetes	☐Y/☐N Hepatitis	☐Y/☐N Sleep Apnea	☐Y/☐N Seizures

Other _____

If you have marked any of the above, when? _____

_____

ALLERGIES

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS, FOODS OR ENVIRONMENTAL ELEMENTS? ☐YES ☐NO

If yes, please list all allergies and the reaction experienced.

_____ _____

_____ _____

PATIENT HISTORY FORM 2

Southwest Joint Replacement & Sports Medicine Center

SURGERIES/HOSPITALIZATIONS

HAVE YOU EVER HAD ANY OF THE FOLLOWING: *ANSWER EACH WITH YES/NO AS APPLIES & DATE OF SURGERY*

☐Y/☐N Previous orthopedic fractures or surgeries: _____

☐Y/☐N Appendectomy-Date:_____ ☐Y/☐N Gall Bladder-Date:_____ ☐Y/☐N Hysterectomy-Date:_____

☐Y/☐N Back Surgery-Date:_____ ☐Y/☐N Heart Surgery-Date:_____ ☐Y/☐N Thyroid-Date:_____

☐Y/☐N CABG-Date:_____ ☐Y/☐N Hemorrhoids-Date:_____ ☐Y/☐N Tonsillectomy-Date:_____

☐Y/☐N Cancer Surgery-Date:_____ ☐Y/☐N Hernia Repair-Date:_____

☐Y/☐N Other Surgeries & Date: _____

_____

Have you been hospitalized other than for the surgeries listed above ☐Y ☐N

If yes please list when & why: _____

FAMILY HISTORY

☐ **Check this box and skip this section if you recently completed the portal questionnaire**

☐ **I do not know the medical history of my biological parents or other family members.** (Go to next section, SOCIAL HISTORY)

MOTHER: ☐ Alive-Age: _____
Deceased at age: _____ Due to: _____

FATHER: ☐ Alive-Age: _____
Deceased at age: _____ Due to: _____

ARE THERE ANY ILLNESSES THAT RUN IN THE FAMILY?			(PLEASE CIRCLE ALL THAT APPLY)				
Diabetes	YES	NO	Relation:	DAD	MOM	SISTER	BROTHER
Hypertension (HTN)	YES	NO	Relation:	DAD	MOM	SISTER	BROTHER
Breast Cancer	YES	NO	Relation:	DAD	MOM	SISTER	BROTHER
Heart Disease (CAD)	YES	NO	Relation:	DAD	MOM	SISTER	BROTHER
Lung Cancer	YES	NO	Relation:	DAD	MOM	SISTER	BROTHER
Colon Cancer	YES	NO	Relation:	DAD	MOM	SISTER	BROTHER
Heart Attack	YES	NO	Relation:	DAD	MOM	SISTER	BROTHER
High Cholesterol	YES	NO	Relation:	DAD	MOM	SISTER	BROTHER
Asthma	YES	NO	Relation:	DAD	MOM	SISTER	BROTHER
Other: _____			Relation:	DAD	MOM	SISTER	BROTHER

SOCIAL HISTORY

☐ **Check this box and skip this section if you recently completed the portal questionnaire**

ALCOHOL USE
- ☐ Does not use alcohol
- ☐ Uses alcohol

Frequency of drinking:
- ☐ never
- ☐ rarely
- ☐ socially
- ☐ daily

Amt: _____drinks / week

TOBACCO STATUS
- ☐ non tobacco user
- ☐ never a smoker
- ☐ current every day smoker
- ☐ current some day smoker
- ☐ former smoker
  -Quit date: _____
- ☐ smokeless tobacco user

# of yrs smoked: _____
Amt: _____ per day

MARITAL STATUS
- ☐ Married
- ☐ Divorced
- ☐ Single
- ☐ Widow/Widower
- ☐ Partner
- ☐ Domestic Partner

OCCUPATION/WORK
- ☐ employed full time
- ☐ employed part time
- ☐ homemaker
- ☐ student
- ☐ not employed
- ☐ retired
- ☐ disabled

Occupation: _____

PATIENT HISTORY FORM 3

Southwest Joint Replacement & Sports Medicine Center

REVIEW OF SYSTEMS ☐ **Check this box and skip this section if you recently completed the portal questionnaire**

Do you currently have any of the following medical symptoms? Circle all that apply.

CONSTITUTIONAL ☐ Chills ☐ Fatigue ☐ Fever ☐ Night sweats ☐ Weight gain ☐ Weight loss _____	**CARDIOVASCULAR** ☐ Chest pain ☐ Heart attack ☐ Irregular heart rate ☐ Palpitations ☐ Fainting _____	**GENITOURINARY** ☐ Incontinence ☐ UTI _____	**ENDOCRINE** ☐ Heat/Cold intolerance ☐ Thyroid problems ☐ Unusual weight gain _____
SKIN/BREAST ☐ Breast lump or mass ☐ Bruising ☐ Rash/Redness _____	**RESPIRATORY** ☐ Cough ☐ Shortness of breath _____	**MUSCULOSKELETAL** ☐ Joint pain ☐ Muscle weakness ☐ Swollen joints ☐ Arthritis _____	**LYMPHATICS** ☐ Abnormal bleeding ☐ Anemia ☐ Enlarged lymph nodes _____
EYES ☐ Blurred vision ☐ Difficulty seeing ☐ Double vision _____	**GASTROINTESTINAL** ☐ Abdominal pain or swelling ☐ Acid reflux ☐ Constipation ☐ Diarrhea ☐ Ulcers ☐ Vomiting _____	**NEUROLOGIC** ☐ Dizziness ☐ Headaches ☐ Numbness _____	**ALLERGIC/IMMUNOLOGIC** ☐ Hives ☐ Metal or Nickel sensitivity _____
EARS/NOSE/THROAT ☐ Deafness ☐ Hearing changes ☐ Nasal congestion ☐ Nose bleeds ☐ Sore throat _____		**PSYCHIATRIC** ☐ Anxious ☐ Confusion ☐ Depressed _____	**HEMATOLOGY** ☐ Bleeding ☐ Blood clots _____

Patient/Responsible Party Signature _____ **Date** _____

I have read and reviewed this patient history form.

*Physician Signature:*_____ *Date:*_____ *Time:*_____

HOW DID YOU LEARN ABOUT US? (Circle all that apply)

☐ Referring Provider	☐ Google+	☐ Other Social Media	☐ Care Now
☐ Family/Friend	☐ Online Profile	☐ Other Physician Profile	☐ Marketing Mailer
☐ Website	☐ Facebook	☐ Living Well Magazine	☐ Medical City Dallas Hospital/ER
☐ Search Engine	☐ D Magazine	☐ Health Grades or Vitals	

☐ Other (please specify) _____