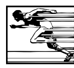

Sports Occupational & Knee Surgery, P.A.

Patient's Medical History

Patient Name ______________ Age: ______ ❑F ❑M Today's Date: ______________

Dominant hand ❑R ❑L Height ________ Weight ________ Occupation ______________

Who requested that you visit this office? ❑Doctor Name ______________ ❑Self-referral

Have you seen either ❑ Dr. Holmes or ❑ Dr. McCarty prior to this visit? ❑Yes ❑No

Do you have any family members that see ❑ Dr. Holmes or ❑ Dr. McCarty?

Would you like to receive information by email? ❑Yes ❑No email address ______________

1. * (Chief Complaint) Main reason for visit? ❑Pain ❑Numbness ❑Weakness ❑Other ______________

2. * (Location) What body part is involved? (Check below)

Neck ❑ and radiates to...	❑R arm ❑L arm	Shoulder ❑R ❑L	Elbow ❑R ❑L	Hand ❑R ❑L	Pelvis ❑R ❑L	Knee ❑R ❑L	Foot ❑R ❑L
Back ❑ and radiates to...	❑R leg ❑L leg	Arm ❑R ❑L	Wrist ❑R ❑L	Finger ❑R ❑L	Hip ❑R ❑L	Ankle ❑R ❑L	Toe ❑R ❑L

3. * (Duration) How long has this problem been present? ________ ❑Days ❑Weeks ❑Months ❑Years

4. Check the ONE box below that best describes how your problem started. Then use the space to the right to answer the ONE question below the box you checked. Use as much space as needed.

❑**NO INJURY** (onset was ❑Gradual ❑Sudden) ANSWER / COMMENTS:

Why do you think it started? ______________

❑**INJURY** (from Accident or Sport NOT work or auto) ______________

Date: ________ Where and how did it happen? ______________

What sport?________ School: ____________ ______________

❑**INJURY AT WORK** (Date __________) ______________

From a ❑lift ❑twist ❑bend ❑pull ❑reach ______________

❑**WORK RELATED (BUT NO INJURY)** ______________

Date: ________ How did job cause this problem? ______________

❑**AUTO ACCIDENT** ______________

Date: ________ How was car hit? ______________

Please check the box in each category that best describes your problem:

5. * SEVERITY of pain? ❑Mild ❑Moderate ❑Severe ❑Extremely severe ______________

6. * QUALITY of pain? ❑Sharp ❑Dull ❑Stabbing ❑Throbbing ❑Aching ❑Burning ______________

7. * TIMING of pain? ❑Constant ❑Comes & goes (intermitent) Does pain wake you from sleep? ❑Yes ❑No

8. Do you have: ❑Swelling ❑Bruise ❑Numbness ❑Tingling ❑Weakness ❑Loss of bowel or bladder control?

9. Since my problem started, it is: ❑Getting better ❑Getting worse ❑Unchanged ______________

10. What makes symptoms worse? ❑Standing ❑Walking ❑Lifting ❑Exercise ❑Twisting ❑Lying in bed ❑Bending ❑Squatting ❑Kneeling ❑Stairs ❑Sitting ❑Coughing ❑Sneezing

11. Which treatments have you tried? ❑Injection ❑Brace ❑Therapy ❑Cane/Crutch

12. What medications have you taken for this problem? ______________

13. Were you seen in an Emergency Room for this problem? ❑Yes ❑No Which ER and date? ______________

14. What tests have you had? ❑X-rays ❑MRI ❑CAT scan ❑Bone scan ❑Nerve test (EMG/NCV)

15. Have you already had surgery for this problem? ❑Yes ❑No Surgeons Name ______________ Date ________

FOR OFFICE USE ONLY: Reviewed for completeness by ______________ Date ________

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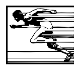

Sports Occupational & Knee Surgery, P.A.

Rev. Aug 2012

Patient's Medical History

Medication	Dose	Medication	Dose

2. Are you ALLERGIC to any medications? ☐ Yes ☐ No Please list: ______________________

____

3. List other products that you are ALLERGIC to (e.g. eggs, latex, iodine, etc.) ______________________

4. Have you ever had SURGERY? ☐ Yes ☐ No (Please list details below)

Surgery	Date	Surgery	Date

5. Did you have any adverse reactions to anesthesia? ☐ Yes ☐ No Please describe ______________________

6. Do you have any MEDICAL PROBLEMS? ☐ Yes ☐ No (Please check below or list)

☐ Diabetes ☐ High blood pressure ☐ Heart Problems ☐ Blood Clots ☐ Asthma
☐ Bronchitis ☐ Emphysema ☐ Kidney problems ☐ Hepatitis ☐ Thyroid disease
☐ Ulcers ☐ Seizures ☐ Stroke ☐ Tuberculosis ☐ Rheumatoid arthritis
☐ Cancer ______________________ ☐ Other ______________________

REVIEW OF SYSTEMS

1. Have you ever had a prior problem with the same Orthopaedic condition you are here for today? ☐ Yes ☐ No

Do you have OTHER JOINTS with ☐ morning stiffness, ☐ swelling, or ☐ pain?

(Please check any that apply to you or mark NONE)

						NONE
2.	☐ Heartburn ☐ Nausea	☐ Vomiting	☐ Blood in stool	☐ Stomach pain with anti-inflammatory pills		☐
3.	☐ Excessive thirst	☐ Heat or cold intolerance				☐
4.	☐ Weight loss	☐ Fever	☐ Loss of appetite			☐
5.	☐ Blurred vision	☐ Double vision	☐ Vision loss			☐
6.	☐ Hearing loss	☐ Hoarseness	☐ Trouble swallowing			☐
7.	☐ Chest Pain	☐ Palpitations				☐
8.	☐ Chronic cough	☐ Shortness of breath				☐
9.	☐ Painful urination	☐ Blood in urine				☐
10.	☐ Rash	☐ Skin ulcers	☐ Lumps	☐ Psoriasis		☐
11.	☐ Headaches	☐ Dizziness				☐
12.	☐ Depression	☐ Drug/alcohol addiction	☐ Sleep disorder			☐
13.	☐ Easy bleeding	☐ Easy bruising	☐ Anemia			☐

FAMILY HISTORY

Has any direct relative had any of the following? ☐ Yes ☐ No (please mark all that apply)

☐ Same Orthopaedic condition you are being seen for today ☐ Rheumatoid arthritis ☐ Diabetes
☐ High blood pressure ☐ Heart disease ☐ Reaction to anesthesia

SOCIAL HISTORY

Do you use tobacco? ☐ Yes ☐ No Packs per day ________ Alcohol use? ☐ Yes ☐ No How often? ☐ Daily ☐ Other ______

Marital status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

☐ Student Are you currently working? ☐ Yes ☐ No Employer: ______________________

If 'No', how long have you been off work? ______________________

Patient Name ______________________ Signature ______________________ Date ____________

FOR OFFICE USE ONLY: Reviewed for completeness by ____________________ Date ______________

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