SCHOFIELD, HAND & BRIGHT ORTHOPAEDICS, PLLC
PATIENT HISTORY

PLEASE FILL OUT COMPLETELY PATIENT NAME_____ DATE_____

AGE_____YRS SEX___M___F HEIGHT ____FT_____IN WEIGHT_____LBS. OCCUPATION_____

REFERRED BY_____ FAMILY M.D._____

** DESCRIBE **PROBLEM** YOU ARE BEING SEEN FOR TODAY_____

PHARMACY NAME_____ PHARMACY PHONE_____

ARE YOU **ALLERGIC** TO ANY MEDICATIONS? ____YES ____NO ** IF YES, **PLEASE LIST ALL**_____

DISABLED? ___YES ___NO
IS PROBLEM WORK RELATED? ___YES ___NO
SEEN IN THE EMERGENCY ROOM? ___YES ___NO
LAWSUIT INVOLVED? ___YES ___NO

HAD RECENT X-RAY STUDIES FOR TODAY'S PROBLEM? ___YES ___NO

X-RAY STUDIES DONE AT_____

Are You on ***Blood Thinning*** medication? __Yes __No

MEDICAL HISTORY
CHECK ALL THAT APPLY

_____ ANEMIA
_____ ARTHRITIS/ RHEUMATOID
_____ ASTHMA/COPD
_____ BACK DISORDERS
_____ BLEEDING DISEASES
_____ CANCER. Where?
_____
_____ DIABETES
_____ HEART DISEASE/HEART ATTACK; IF YES, WHEN? _____
_____ HEPATITIS
_____ HIGH BLOOD PRESSURE
_____ HIV (AIDS)
_____ GALLBLADDER DISEASE
_____ GOUT
_____ COLOTIS/DIVERTICULITIS
_____ HIATAL HERNIA
_____ KIDNEY STONE / DISEASE
_____ BLOOD CLOTS
_____ STROKE
_____ THYROID DISEASE
_____ FRACTURE
WHERE?_____
_____ OTHER. List All:

_____

_____

OTHER PROBLEMS (ROS)
CHECK ALL THAT APPLY

____ PROBLEMS WITH ANESTHESIA
____ EYE / NOSE / THROAT PROBLEMS
____ LOSS OF HEARING
____ INDIGESTION / HEARTBURN
____ INTESTINAL BLEEDING
____ SHORTNESS OF BREATH
____ CHILLS OR FEVER
____ HEART / CHEST PAIN / ANGINA
____ ABNORMAL HEARTBEAT
____ MUSCLE WEAKNESS
____ JOINT PAIN / STIFFNESS
____ CALF CRAMPS WHEN WALKING
____ RECENT WEIGHT LOSS
____ LEG / SKIN ULCERS
____ MENTAL ILLNESS / ADDICTION
____ DIARRHEA

PREVIOUS SURGERIES
CHECK ALL THAT APPLY

_____HEART BYPASS / STENTS
_____TONSILS
_____GALLBLADDER
_____APPENDIX
_____PROSTATE
_____HYSTERECTOMY
_____CANCER?_____
_____BACK / DISC
_____ BONE AND/OR JOINT
WHERE? _____
_____OTHER List:_____

_____

SOCIAL HISTORY

_____ MARRIED____SINGLE____ DIVORCED

PRESENTLY LIVING ALONE?___YES___NO

DO YOU **SMOKE**? ___YES___NO___NEVER

HOW MANY PACKS?_____

IF NO, WHEN DID YOU QUIT?_____

ALCOHOL? ___NEVER ___ OCCASIONAL

___MODERATE TO HEAVY

Marijuana/Cocaine/Heroin? ___ NEVER
___ PAST PROBLEM

FAMILY HISTORY
(PARENTS OR SIBLINGS)
CHECK ALL THAT APPLY

_____STROKE
_____HEART TROUBLE
_____DIABETES
_____ARTHRITIS
_____GOUT
_____MENTAL ILLNESS
_____KIDNEY DISEASE
_____CANCER
_____BLEEDING DISORDERS
_____ALCOHOLISM
_____AIDS
_____TB
_____OTHER. List all:_____

_____

CURRENT MEDICATIONS

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

___ More, Please See List

OTHER PROBLEMS NOT LISTED HERE

_____
_____
_____
_____
_____
_____

_____ **, M.D.**

(REV 5/05)