WESTERN ORTHOPAEDICS
1830 Franklin Street, Suite 450
Denver, Colorado 80218

James C. Holmes, M.D.
Timothy J. Birney, M.D.
Edward H. "Ted" Parks, M.D.
Armodios M. Hatzidakis, M.D.
Rajesh Bazaz, M.D.
Kevin K. Nagamani, M.D.
Brian J. White, M.D.
Steven M. Traina, M.D.
Thomas G. Mordick II, M.D.
Benjamin W. Sears, M.D.
Sean Baran, M.D.
Edward (Patrick) Curry, M.D.

PATIENT HISTORY FORM

Name _____ DOB _____ Date _____

Height _____ Weight _____ Age _____

Who referred you to us? _____

Who is your primary care physician? _____

Date of injury of accident _____ Type of Accident W/C ❑ Auto ❑ Other ❑

Were X-rays taken? _____ Yes ❑ No ❑ Where? _____

Date stopped work (if applicable) _____ Date returned to work _____

Area of body injured _____ Right ❑ Left ❑

How injury/illness happened/reason for today's visit: _____

_____

Have you had any other treatment for this problem? Yes ❑ No ❑

If yes, please explain _____

_____

Significant past and current medical problems: _____

_____

Past surgeries and dates: _____

_____

_____

List all medications (including birth control and over-the-counter medications you routinely take): _____

_____

Medication Allergies: _____

_____

Over

Patient History Form cont.

Are you allergic to: Iodine ❑ Adhesive Tape ❑ Latex ❑ Merthiolate ❑ Plastic Bandages ❑

Social History

Have you smoked cigarettes? Yes ❑ No ❑ How many packs per day? _____

How many years? _____

Do you currently smoke cigarettes? Yes ❑ No ❑ How many packs per day? _____

How many years? _____

Have you chewed tobacco? Yes ❑ No ❑ How many cans a day? _____

How many years? _____

Do you currently chew tobacco? Yes ❑ No ❑ How many cans a day? _____

How many years? _____

Do you drink alcoholic beverages? Yes ❑ No ❑ Average drinks per week _____

Have you used "street" drugs? Yes ❑ No ❑ How many years? _____ Type _____

Have you ever taken steroids? Yes ❑ No ❑ When? _____

Occupation or retired occupation: _____

Exercise history/sports: _____

Family history: Medical problems of parents, brothers, sisters, and/or children such as cancer, heart disease, arthritis, high blood pressure, diabetes, etc: _____

_____

_____

Are you pregnant? Yes ❑ No ❑

Are you trying to get pregnant? Yes ❑ No ❑

REVIEW OF SYSTEMS

Check any problems you currently experience or have in the past

Head & Neck
- ❑ Nose Bleeds
- ❑ Pain and tingling with neck motion
- ❑ Neck lumps or swelling
- ❑ Visual difficulties
- ❑ N/A

Respiratory
- ❑ Shortness of breath
- ❑ Wheezing
- ❑ Coughing blood
- ❑ N/A

Heart & Blood Vessel
- ❑ Chest pain
- ❑ Pounding of the heart
- ❑ Congestive heart failure
- ❑ Fainting or blackouts
- ❑ Foot or ankle swelling
- ❑ Blood clots
- ❑ High blood pressure
- ❑ Heart murmur
- ❑ Phlebitis
- ❑ Anemia
- ❑ Blood transfusions
- ❑ N/A

Musculoskeletal/Neuro
- ❑ Arthritis
- ❑ Muscle or nerve disorder
- ❑ Numbness or tingling
- ❑ Strokes
- ❑ Fractures:
  (Which bones and when):

  _____
  _____
  _____
- ❑ N/A

Psychological
- ❑ Depression
- ❑ Anxiety
- ❑ Chemical dependency
- ❑ Seizures
- ❑ N/A

Skin Problems
- ❑ Bruise Easily
- ❑ Open sores
- ❑ N/A

Digestive
- ❑ Nausea
- ❑ Vomiting blood
- ❑ Liver problems
- ❑ Bowel movement abnormalities
- ❑ Rectal bleeding
- ❑ Ulcers
- ❑ Heartburn
- ❑ N/A

Urinary & Reproductive
- ❑ Burning with urination
- ❑ Urinating more than 5-6 times daily
- ❑ Blood in urine
- ❑ Trouble with urine flow
- ❑ Prostate problems
- ❑ Unusual vaginal bleeding
- ❑ N/A

Endocrine
- ❑ Diabetes
- ❑ Thyroid
- ❑ Weight change recently
- ❑ N/A

Anesthesia
- ❑ Anesthesiologist had difficulties inserting a breathing tube
- ❑ You or family members had high fever or complications with anesthesia
- ❑ Nausea or vomiting after surgery
- ❑ N/A

Type of Anesthesia that caused reaction

_____
Which surgery?

_____
When?

_____
Reactions:

_____
_____
_____

- ❑ N/A