

ATLANTIS ORTHOPAEDICS  
PATIENT HISTORY SHEET

PENNER

NORRIS

ROUTMAN

FRANCISCO

Name \_\_\_\_\_ Acct#: \_\_\_\_\_ Date: \_\_\_\_\_

Occupation: \_\_\_\_\_ Age: \_\_\_\_\_ Are you Right or Left handed? (circle one)

Are you still working in spite of your illness/injury?  YES  NO If no, last day worked \_\_\_\_\_

Did you have an injury to cause your symptoms?  YES  NO Height: \_\_\_\_\_ Weight: \_\_\_\_\_

If YES, state where it happened (circle one) WORK HOME AUTO OTHER (Where?) \_\_\_\_\_

Explain how you were injured: \_\_\_\_\_

Who is your Primary Care/Family Doctor? \_\_\_\_\_

Who asked you to come to our office? (circle one)

DOCTOR \* NURSE PRACTITIONER \* PHYSICIAN ASSISTANT \* EMERGENCY ROOM \* OTHER \* NONE (SELF)

What is his/her name?: \_\_\_\_\_

\*Date of Accident/Injury? \_\_\_\_\_ (Onset)

\* Which body part is involved? \_\_\_\_\_ (Location)

CIRCLE ONE: Right Left Both

I have reviewed this patient's  
medical history sheet as they  
have recorded it.

\* How long have you had this pain? \_\_\_\_\_ (Duration)

\* List all activities which cause pain: \_\_\_\_\_ (Context)

\_\_\_\_\_  
Provider's Signature

\* Describe the pain: \_\_\_\_\_ (Quality)

\* Rate the pain (please circle: 0= no pain; 10= most severe) (Severity)

\_\_\_\_\_  
Date

0 1 2 3 4 5 6 7 8 9 10

**REVIEW OF SYSTEMS**

**CONSTITUTUIONAL:**

Have you had any recent coughs or colds?

YES

NO

**EYES:**

Do you have any tearing, eye pain, pressure or change in vision?

YES

NO

If yes, please explain: \_\_\_\_\_

**EAR, NOSE & THROAT:**

Do you have any sore throats?

YES

NO

Do you have difficulty hearing?

YES

NO

**CARDIOVASCULAR:**

Do you have any chest or arm pain on exertion?

YES

NO

Do you have chronic cough either dry or with blood or sputum?

YES

NO

**GASTROINTESTINAL:**

Do you have or have you had any of the following?

Ulcer Disease

YES

NO

Gastritis

YES

NO

Colitis

YES

NO

Diverticulitis

YES

NO

Hepatitis

YES

NO

**GENITOURINARY:**

Do you have any of the following?

Prostate trouble?

YES

NO

Do you have to get up at night to urinate?

YES

NO

Do you have frequency of urination?

YES

NO

**MUSCULOSKELETAL:**

Do you have any chronic or intermittent back pain?  YES  NO  
 Do you have any problems with any other joints such as pain, Swelling, or weakness?  YES  NO  
 If YES, please explain: \_\_\_\_\_

**SKIN:**

Do you have any rashes, lesions, lumps or sores?  YES  NO  
 If YES, please explain: \_\_\_\_\_

**NEUROLOGICAL:**

Do you have any problems with seizures or other nervous disorders that require medication?  YES  NO  
 If YES, please explain: \_\_\_\_\_  
 Do you have any previous history of stroke?  YES  NO  
 Do you have any problems with headache or dizziness?  YES  NO

**PSYCHIATRIC:**

Do you have any drug or alcohol addiction?  YES  NO  
 Do you have any problems with depression?  YES  NO

**ENDOCRINE:**

Do you have any problems with excessive thirst or intolerance to heat or cold?  YES  NO  
 Do you have any type of glandular problem including diabetes or thyroid?  YES  NO

**HEMATOLOGY:**

Do you have any problems with easy bleeding?  YES  NO  
 Do you have any problems with easy bruising?  YES  NO  
 Do you have any problems with anemia?  YES  NO  
 Have you ever had a blood clot?  YES  NO

**ALLERGIES:**

Are you allergic to any medications?  YES  NO  
 If YES, please list: \_\_\_\_\_

**PAST MEDICAL HISTORY:**

Do you have any of the following?  
 Heart Trouble  YES  NO  
 Diabetes  YES  NO  
 Tuberculosis  YES  NO  
 High Blood Pressure  YES  NO  
 Asthma/COPD  YES  NO  
 Pneumonia  YES  NO  
 Cancer  YES  NO Type/Location \_\_\_\_\_  
 List all previous surgeries: \_\_\_\_\_  
 List any other medical illnesses: \_\_\_\_\_

**FAMILY HISTORY:**

Has or does anyone in your family have any of the following?  
 Heart Trouble  YES  NO Relationship: \_\_\_\_\_  
 Diabetes  YES  NO Relationship: \_\_\_\_\_  
 Tuberculosis  YES  NO Relationship: \_\_\_\_\_  
 High Blood Pressure  YES  NO Relationship: \_\_\_\_\_  
 Pneumonia  YES  NO Relationship: \_\_\_\_\_  
 Cancer  YES  NO Relationship: \_\_\_\_\_  
 Sudden Death  YES  NO Relationship & Cause: \_\_\_\_\_

**SOCIAL HISTORY:**

Do you live alone?  YES  NO  
 Do you have a living will?  YES  NO  
 Do you use tobacco?  YES  NO Form of Tobacco: \_\_\_\_\_  
 State frequency of daily use (eg., 2 packs per day): \_\_\_\_\_  
 Do you drink alcoholic beverages?  YES  NO Average # drinks per week: \_\_\_\_\_  
 Do you exercise?  YES  NO  
 If YES, what type of exercise? \_\_\_\_\_  
 Are you on any special diet?  YES  NO What type: \_\_\_\_\_

PATIENT'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_



