Steel Valley Orthopedic Associates – Patient Health History

Date: ____________________

Name: ____ **Date of Birth:** ____________________

Age: _______ **Height:** _____ **Weight:** _____ ❑ **Female** ❑ **Male** **Dominant Hand:** ❑ Left ❑ Right

PCP: ____ **Referred by:** ____________________________________

What is the medical reason for your visit today: ____

What caused the problem: ❑ Car accident ❑ Sports injury ❑ Slip/Fall ❑ Work injury ❑ Unknown ❑ other: ____

Injury date: __________ **How long have you had this problem?** ___ Days ___Weeks ___ Months ___Years

Was injury at work? ❑ Yes ❑ No **If yes, please explain:** ____
____

Is injury auto related? ❑ **Yes** ❑ **No**

If yes, were you wearing a seatbelt? ❑ Yes ❑ No
Were airbags deployed? ❑ Yes ❑ No
Were you driving? ❑ Yes ❑ No
What was the speed on impact? _________
Were you rear ended, side impact, head on collision etc. please explain : ________________________________

What severity level would you use to describe your pain? (On a scale of 0-10 0 = no pain 10 = worst pain)

❑ **0** ❑ **1** ❑ **2** ❑ **3** ❑ **4** ❑ **5** ❑ **6** ❑ **7** ❑ **8** ❑ **9** ❑ **10**

How would you describe the pain associated with this injury? (check all that apply)

❑ aching ❑ intermittent ❑ burning ❑ throbbing ❑ excruciating ❑ other _________________

Please mark past or current treatment of this problem: (check all that apply) ❑ None/Nothing

❑ Emergency Room ❑ Primary Care Doctor ❑ Physical therapy ❑ Occupational therapy
❑ Surgery ❑ ice/heat ❑ brace/sling ❑ other: ________________

Do any of the following improve the problem? ❑ None/Nothing

❑ brace/wrap ❑ rest ❑ cold application ❑ sleeping ❑ cortisone injection
❑ heat application ❑ medication ❑ cane/crutches/walker ❑ other: __________________

What activities make the problem worse? ❑ Nothing

❑ grasping ❑ standing ❑ twisting ❑ gripping ❑ walking
❑ repetitive motions ❑ lifting ❑ climbing stairs ❑ descending stairs ❑ squatting
❑ kneeling ❑ overhead reaching ❑ sleeping on side ❑ other: __________________________

Name ____ DOB: _______________

Patient's Social History

Are you allergic to any medications? (Please list)

Medication	Reaction

Do you take any medications daily, including over the counter and dietary supplements? (please list)

Medication	Dosage	How often do you take?

Are you allergic to Latex? ❑ Yes ❑ No
Are you allergic to contrast dye? ❑ Yes ❑ No
Are you allergic to tape/bandaids/glue or adhesive? ❑ Yes ❑ No
Do you have any food allergies/metal allergies/shellfish/or beestings? ❑ Yes ❑ No
Please list - ____

Tobacco Use: ❑ Never ❑ Previous ❑ Current Average packs per day: _________________
Alcohol Use: ❑ Yes ❑ No Average drinks per day: _______________
Drug Use: ❑ Never ❑ Previous ❑ Current Comments: ___________________________
Do you exercise regularly? ❑ Yes ❑ No Exercise type: _______________________________________
Occupation: ____
Do you live ❑ alone ❑ with spouse/family ❑ assisted living ❑ nursing facility
Type of residence ❑ one story living ❑ two story home ❑ apartment

Please list all physicians that you are currently treating with for any medical conditions –
(example, cardiologist, rheumatologist, primary care physician)

Name	Specialty	Phone Number

Pharmacy	Location	Phone Number

Name ____ DOB: ______________

Patient's Past Medical History ❑ None

Condition		Condition	
AIDS	❑ Yes	Liver Problems	❑ Yes
Alcoholism	❑ Yes	Malignant Hyperthermia	❑ Yes
Alzheimer's/Dementia	❑ Yes	MRSA (Methicillin-resistant Staphylococcus aureus)	❑ Yes
Anemia	❑ Yes	Neurological Disorders	❑ Yes
Arthritis	❑ Yes	Neuropathy	❑ Yes
Asthma	❑ Yes	Osteoporosis	❑ Yes
Bleeding Problems	❑ Yes	Pace Maker/Defibrillator	❑ Yes
Blood Transfusion	❑ Yes	Parkinson's Disease	❑ Yes
Bowel Problems	❑ Yes	Peripheral Artery Disease	❑ Yes
Cancer type:______________________________	❑ Yes	Pinched nerve	❑ Yes
Carpal tunnel syndrome	❑ Yes	Previous fractures	❑ Yes
Coronary Artery Disease	❑ Yes	Psoriasis	❑ Yes
Diabetes	❑ Yes	Psychiatric problems	❑ Yes
DVT/Blood Clots	❑ Yes	Pulmonary Embolism	❑ Yes
Fragile or easily torn skin	❑ Yes	Rheumatic Fever	❑ Yes
Frequent Headaches	❑ Yes	Rheumatoid Arthritis	❑ Yes
Fibromyalgia	❑ Yes	RSD (Reflex Sympathetic Syndrome Disease)	❑ Yes
GERD/Reflux	❑ Yes	Seizure /Epilepsy	❑ Yes
Glaucoma	❑ Yes	Sickle Cell Anemia	❑ Yes
Gout	❑ Yes	Sleep Apnea	❑ Yes
Hepatitis	❑ Yes	C-PAP Machine	❑ Yes
Hiatal Hernia	❑ Yes	Stroke	❑ Yes
HIV Positive	❑ Yes	Thyroid Disease	❑ Yes
Hypercholesterolemia	❑ Yes	Tuberculosis	❑ Yes
Hypertension	❑ Yes	Ulcerative colitis	❑ Yes
Joint pain or swelling	❑ Yes	Ulcers – skin	❑ Yes
Kidney Disease	❑ Yes	Ulcers – stomach	❑ Yes
Dialysis	❑ Yes	Problem with anesthesia	❑ Yes
		Other:	

Patient's Surgical History

Surgery		Surgery	
None	❑ Yes	Gastric Bypass	❑ Yes
Adenoidectomy	❑ Yes	Hernia Repair	❑ Yes
Appendectomy	❑ Yes	Hip Replacement	❑ Yes
Arthroscopy – Ankle	❑ Yes	Hysterectomy	❑ Yes
Arthroscopy – Knee	❑ Yes	Knee Replacement	❑ Yes
Arthroscopy – Shoulder	❑ Yes	Prostate Surgery	❑ Yes
Breast Cancer Surgery	❑ Yes	Skin Cancer Surgery	❑ Yes
Cancer Surgery type:______________________	❑ Yes	Spine Surgery	❑ Yes
Carpal tunnel Surgery	❑ Yes	Thyroid Surgery	❑ Yes
Coronary Artery Bypass	❑ Yes	Tonsillectomy	❑ Yes
Cosmetic Surgery	❑ Yes	Transplant Surgery	❑ Yes
Colon Resection	❑ Yes	Trigger Finger Surgery	❑ Yes
C-Section	❑ Yes	Wisdom teeth	❑ Yes
Fracture Surgery explain:__________________	❑ Yes	Other:	
Gallbladder Surgery	❑ Yes		

Name ____________________ DOB: ____________

Family History - Please check if your parents or siblings have, or have had, any of these conditions.

Condition		Condition	
None	❑ Yes	Joint pain or swelling	❑ Yes
Alcoholism	❑ Yes	Kidney Disease	❑ Yes
Alzheimer's/Dementia	❑ Yes	Liver Problems	❑ Yes
Anemia	❑ Yes	Malignant Hyperthermia	❑ Yes
Arthritis	❑ Yes	Neuropathy	❑ Yes
Asthma	❑ Yes	Osteoporosis	❑ Yes
Bleeding Problems	❑ Yes	Pace Maker	❑ Yes
Blood Clots/Phlebitis	❑ Yes	Parkinson's Disease	❑ Yes
Blood Transfusion	❑ Yes	Peripheral Artery Disease	❑ Yes
Cancer type:____________________	❑ Yes	Psoriasis	❑ Yes
Coronary Artery Disease	❑ Yes	Pulmonary Embolism	❑ Yes
Diabetes	❑ Yes	Rheumatic Fever	❑ Yes
DVT	❑ Yes	Rheumatoid Arthritis	❑ Yes
Fibromyalgia	❑ Yes	Sickle Cell Anemia	❑ Yes
Gout	❑ Yes	Stroke	❑ Yes
Hypercholesterolemia	❑ Yes	Problem with anesthesia	❑ Yes
Hypertension	❑ Yes	Other:	

Review of Systems - Please check all symptoms that you are currently experiencing. ❑ None

System				
General	❑ Fevers	❑ Night sweats	❑ Chills	❑ Weight loss
Eyes	❑ Blurring	❑ Double vision	❑ Vision loss	
Ears/Nose/Throat	❑ Hearing loss	❑ Nose bleeds	❑ Difficulty swallowing	
Cardiovascular	❑ Chest pain	❑ Palpitations	❑ Fainting	❑ Shortness of breath on exertion
	❑ Ankle swelling	❑ Dizzy/lightheaded		
Respiratory	❑ Shortness of breath	❑ Cough	❑ Wheezing	
Gastrointestinal	❑ Nausea	❑ Bowel incontinence	❑ Diarrhea	❑ Vomitting ❑ Dark or bloody stools
Genitourinary	❑ Pain with urination	❑ urinary frequency	❑ Frequent night-time urination	❑ Incontinence
Musculoskeletal	❑ Gout	❑ Muscle weakness	❑ Inflammatory arthritis	❑ Osteoporosis
Skin	❑ Sores/Ulcers	❑ Rash		
Neurologic	❑ Seizures	❑ Numbness/tingling	❑ Difficulty walking	❑ Vertigo
Endocrine	❑ Excessive thirst	❑ Frequent urination	❑ Heat/Cold Intolerance	
Heme/Lymphatic	❑ Abnormal bruising	❑ Easy Bleeding		
Allergy/Immunology	❑ Hay fever	❑ Persistent infections	❑ HIV exposure	

Office Use Only

Reviewed By: ____________________ Date: __________

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