BIENVILLE
Orthopaedic Specialists

Patient History Worksheet

This practice utilizes an electronic method of medical record keeping. This worksheet will assist our physicians and nurses in entering your medical history into your new electronic chart. As always, your personal information will be held in the most confidential manner. Please complete the following sections. ***(check all that apply)***

Patient's Name: _____ **Date of Birth:** _____ **Today's Date:** _____

PAST MEDICAL HISTORY:

- ◯ None
- ◯ AIDS/HIV
- ◯ Alzheimer's Disease
- ◯ Anemia
- ◯ Anxiety Disorder
- ◯ Asthma
- ◯ Bleeding Disorder
- ◯ Blood Clot
- ◯ CAD (Coronary Artery Disease)
- ◯ Cancer
- ◯ Cancer (breast)
- ◯ Cancer (skin)
- ◯ Cataract
- ◯ CHF (Congestive Heart Failure)
- ◯ Concussion
- ◯ COPD (Chronic Pulmonary Disease)
- ◯ Depression
- ◯ Diabetes, Type I
- ◯ Diabetes, Type II
- ◯ Diverticlar Disease
- ◯ Eczema
- ◯ Emphysema
- ◯ Fractures
- ◯ GERD (Acid Reflux)
- ◯ Gout
- ◯ Hemorrhoids
- ◯ Hepatitis: ◯ (A) ◯ (B) ◯ (C)
- ◯ High Cholesterol
- ◯ Hypertension
- ◯ Kidney Disease
- ◯ Lung Disease
- ◯ Lupus
- ◯ Muscle Spasm
- ◯ MVP (Mitral Valve Prolapse)
- ◯ Neuropathy
- ◯ Obesity
- ◯ Osteoarthritis
- ◯ Osteopenia
- ◯ Osteoporosis
- ◯ Parkinson's Disease
- ◯ Peptic Ulcer Disease
- ◯ Peripheral Vascular Disease
- ◯ Polio
- ◯ Renal Failure
- ◯ (RA) Rheumatoid Arthritis
- ◯ Schizophrenia
- ◯ Seizure Disorder
- ◯ Sickle-Cell Anemia
- ◯ Stroke
- ◯ Thyroid Disorder
- ◯ Tuberculosis
- ◯ Valvular Heart Disease
- ◯ _____
- ◯ _____

PAST SURGICAL HISTORY:

- ◯ None
- ◯ Adenoidectomy
- ◯ Appendectomy
- ◯ Bowel Resection
- ◯ Breast Surgery
- ◯ CABG (Heart Bypass)
- ◯ Carotid Endarterectomy
- ◯ Cataract Surgery
- ◯ Cesarean Section
- ◯ Cholecystectomy (GallBladder)
- ◯ Coronary Artery Angioplasty
- ◯ Hernia Repair
- ◯ Hysterectomy
- ◯ - w/ Removal of one or both ovaries
- ◯ Lumpectomy
- ◯ Mastectomy (Breast Removal)
- ◯ Oopherectomy
- ◯ - w/ Removal of one or both ovaries
- ◯ Placement of Stent _____
- ◯ Placement of Pacemaker
- ◯ Sinus Surgery
- ◯ Tonsillectomy
- ◯ TURP (Prostate)

PAST ORTHOPEADIC SURGICAL HISTORY:

- ◯ None
- ◯ ACL Reconstruction: ◯ L ◯ R
- ◯ Amputation
- ◯ Arthroplasty (Total Replacement)
- ◯ Arthroscopy
  - ◯ Knee: ◯ L ◯ R
  - ◯ Shoulder: ◯ L ◯ R
- ◯ Bunionectomy
- ◯ Carpal Tunnel Release: ◯ L ◯ R
- ◯ Cervical Spine (Neck) Surgery
- ◯ Disk Fusion
- ◯ Excision (removal of mass, etc)
- ◯ External Fracture Fixation
- ◯ Fasciectomy
- ◯ Fracture Repair
- ◯ Joint Fusion
- ◯ Lumbar Laminectomy
- ◯ Lumbar Spine Surgery
- ◯ Nerve Repair
- ◯ ORIF (Open Reduction Internal Fixation Fracture)
- ◯ Pin Fixation (fracture)
- ◯ Rotator Cuff Repair
- ◯ Tendon Repair
- ◯ Thoracic Spine Surgery
- ◯ Total Hip Replacement: ◯ L ◯ R
- ◯ Total Knee Replacement: ◯ L ◯ R
- ◯ Total Shoulder Replacement: ◯ L ◯ R
- ◯ Trigger Finger Release
- ◯ Ulnar Nerve Decompression
- ◯ _____
- ◯ _____
- ◯ _____
- ◯ _____
- ◯ _____

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CURRENT MEDICATIONS:

◯ None

Drug Name / Strength	Dose	Frequency	Prescribed By
Example Drug Name 10mg	*2 capsules*	*Twice Daily*	*Dr. Example*

MEDICATION ALLERGIES:

◯ None
◯ Ace Inhibitors
◯ Acetaminophen (Tylenol)
◯ Amoxicillin
◯ Aspirin
◯ Caine's (lidocaine, etc)
◯ Cephalosporins
◯ Codeine
◯ Demerol
◯ Erythromycin
◯ Lorcet
◯ Lortab
◯ Morphine
◯ NSAIDS
◯ Oxycontin
◯ Penicillin
◯ Percocet
◯ Percodan
◯ Phenytoin
◯ Sulfa
◯ Tetracycline
◯ Tylox
◯ Vicodin

◯ Allergy to Poultry / Eggs

Non-Medication Allergies:
◯ _____
◯ _____
◯ _____

MARITAL STATUS:

◯ Divorced
◯ Engaged
◯ Married
◯ Separated
◯ Single
◯ Widowed

SOCIAL HISTORY:

◯ Disabled
◯ Employed
Occupation: _____
◯ Homemaker
◯ Not Presently Employed
◯ Retired
◯ Self Employed
◯ Student

ALCOHOL HISTORY:

◯ Current Every Day
◯ Current Some Days
◯ Former
◯ Never

TOBACCO HISTORY:

*REQUIRED IF 13 OR OLDER

◯ Current Every Day
Packs/Day: _____
◯ Current Some Days
Packs/Day: _____
◯ Former
◯ Never
◯ Chewing Tobacco

DOMINANT HAND:

◯ Ambidextrous
◯ Left Handed
◯ Right Handed

FAMILY HISTORY:

◯ None Provided
◯ Adopted: Unknown Family History
◯ Anemia
◯ Anesthesia Difficulties
◯ Arthritis
◯ Bleeding Disorders
◯ Cancer
◯ Congenital Anomoly
◯ Diabetes
◯ Heart Disease, unspecified
◯ Osteoarthritis
◯ Osteoporosis
◯ Rheumatoid Arthritis
◯ Stroke

Patient's Name - Please Print

Patient's Date of Birth

Signature of Patient or Parent of Minor

Revised 7-28-12 RGB

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REVIEW OF SYSTEMS

Please indicate personal history within the last month or associated with today's complaint.

CONSTITUTIONAL:		
Weight loss	____No	____Yes
Weight gain	____No	____Yes
Fever	____No	____Yes
Fatigue	____No	____Yes
Pregnant	____No	____Yes

EYES:		
Wears glasses or contacts	____No	____Yes

HENT:		
Headaches	____No	____Yes
Dentures	____No	____Yes
Dental problems	____No	____Yes
Gingival bleeding	____No	____Yes

CARDIOVASCULAR:		
Chest pain	____No	____Yes
Irregular heart beats	____No	____Yes
Shortness of breath walking	____No	____Yes
Swelling of hands/feet	____No	____Yes

RESPIRATORY:		
Abnormal sputum production	____No	____Yes
Shortness of breath	____No	____Yes
Wheezing	____No	____Yes
Cough	____No	____Yes

GASTROINTESTINAL:		
Loss of appetite	____No	____Yes
Nausea	____No	____Yes
Vomiting	____No	____Yes
Diarrhea	____No	____Yes
Constipation	____No	____Yes
Blood in stool	____No	____Yes
Abdominal pain	____No	____Yes

GENITOURINARY:		
Frequency (urination)	____No	____Yes
Dysuria (painful urnination)	____No	____Yes
Hematuria (blood in urine)	____No	____Yes
Incontinence	____No	____Yes

INTEGUMENT:		
Rash	____No	____Yes
Itching	____No	____Yes
Pigmentation changes	____No	____Yes

NEUROLOGIC:		
Tingling and numbness	____No	____Yes
Tremors	____No	____Yes
Paralysis	____No	____Yes
Light headed/dizzy	____No	____Yes

MUSCULOSKELETAL:		
Joint pain	____No	____Yes
Joint swelling	____No	____Yes
Muscular weakness	____No	____Yes
Muscle pain	____No	____Yes
Back pain	____No	____Yes
Limitation of motion	____No	____Yes

PSYCHIATRIC:		
Memory loss	____No	____Yes
Anxiety	____No	____Yes
Depression	____No	____Yes
Difficulty sleeping	____No	____Yes

HEME-LYMPH:		
Easy bleeding	____No	____Yes
Easy Bruising	____No	____Yes
Cuts slow to heal	____No	____Yes
Anemia	____No	____Yes

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responisbility to inform the doctor of any changes in my medical status. I also authorize the medical staff to perform the necessary services I may need.

Patient's Name - Please Print _____

Signature of Patient or Parent of Minor _____

Date _____

Patient Date of Birth _____

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