MOORE ORTHOPEDICS AND SPORTS MEDICINE

PATIENT HISTORY

LAST NAME | FIRST NAME | MIDDLE NAME

DATE OF BIRTH (dd/mm/yyyy) | HEIGHT (Ft. & In.) | Weight (lbs)

PATIENT'S GENERAL PHYSICIAN | REFERRING PHYSICIAN

PATIENT'S LOCAL PHARMACY | LOCAL PHARMACY PHONE

What are we treating you for today? ☐ LT (Left Side) ☐ RT (Right Side) ☐ BL (Bilateral)

☐ Foot/Toes ☐ Ankle ☐ Knee ☐ Hip ☐ Shoulder ☐ Elbow

☐ Wrist ☐ Handle ☐ Fingers ☐ Fracture ☐ Back ☐ Neck

How long has it been bothering you?

☐ Hours ☐ Days ☐ Weeks ☐ Months ☐ Years

Is this related to an injury? If yes, please describe what happened, where and when?

What eases your pain?

What makes your pain worse?

Medications you are currently taking or tried for this problem?

Have you had any previous treatment of testing of the area we are treating you for today?
(This includes: surgery, injections, therapy, nerve studies, MRI, X-Rays, etc.)

☐ YES

☒ NO

IF yes, please explain and list the name of the physician or facility that treated you.

PATIENT HISTORY (pg2)

LAST NAME | FIRST NAME | MIDDLE NAME

CURRENT MEDICATIONS | REASON FOR USE | PRESCRIBING PHYSICIAN

MEDICATION ALLERGIES *(include your reaction and name of medication)* | MEDICATION ALLERGIES

Please check any of the following health problems?

- ☐ Cancer & Type
- ☐ Heart Attack, when | Cardiologist
- ☐ Asthma
- ☐ Anxiety
- ☐ Blood Clot
- ☐ COPD
- ☐ Diabetes
- ☐ Depression
- ☐ Gout
- ☐ Fibromyalgia
- ☐ Heart Disease
- ☐ High Blood Pressure / Hypertension
- ☐ Kidney
- ☐ Sleep Apnea
- ☐ Seizure, when | Neurologist
- ☐ Stroke / TIA, when | Neurologist

SURGICAL PROCEDURE | DATE OF PROCEDURE | SURGEON

FAMILY HISTORY *(includes; parents, siblings, grandparents)*

CANCER

DIABETES

HEART DISEASE

BLEEDING DISORDER

SOCIAL HISTORY

- Alcohol Use: ☐ None ☐ Social/Occasional ☐ Moderate ☐ Heavy
- Tobacco: ☐ None ☐ Previous, Quit? ☐ Current / Per Day?