TriHealth
Orthopedic & Spine Institute

PATIENT HISTORY

Date:		
D.O.B.		
S.S.#		
Age		
Gender	Male	Female
Marital Status	S M D W	

Name_____

How did you hear about us? (circle one)	family	friend	doctor	attorney	
other health professional	website	yellow pages			
Name of Person/Physician making referral:					
Primary Care Physician/Family Doctor:					
Please describe the reason for your visit: Body part			right	left	both
Acute injury - new (circle one) yes no		Chronic symptoms - old (circle one) yes no			
How did your symptoms begin? If sudden, describe onset					
On a scale of 1-10 (10 being most severe) circle # that best describes your pain 1 2 3 4 5 6 7 8 9 10					
Approximate date symptoms began or date of injury:					
Resulting from: (circle which applies)	Sports	Accident	Work Related	Involving litigation	
Are symptoms	constant	intermittent	worsening	improving	
Check all that apply	pain	stiffness	swelling	instability	weakness numbness/tingling
What makes symptoms worse?					
What makes symptoms better?					
What previous or formal treatment have you had? (medications, therapy, surgery, injections)					
Were previous treatments helpful to any degree? If so what?					

PAST MEDICAL HIST OR Y

Medical Illnesses (check any illness that you currently have or have had in the past)

☐ arthritis	☐ diabetes	☐ neuropathy	☐ ulcer disease
☐ asthma	☐ glaucoma	☐ rheumatoid disease	☐ vascular disease
☐ bleeding disorder	☐ heart disease	☐ seizure	☐ others
☐ blood clots	☐ hepatitis	☐ stroke	_____
☐ cancer	☐ high blood pressure	☐ substance abuse	_____
☐ cataract	☐ kidney/bladder problem	☐ thyroid	_____

Past Surgeries (list type and year performed)

1_____ 3_____

2_____ 4_____

Your Allergies to Medications (name of medication and reaction): _____

Your Current Medications (name of medication, dose and how often)

1_____ 3_____ 5_____

2_____ 4_____ 6_____

FAMIL Y HIST OR Y

Has any blood relative had any of the following(please check and indicate relationship, i.e. mother, father, sister, brother, etc.)

☐ anesthesia problem	☐ cancer	☐ kidney disease	☐ other
☐ arthritis	☐ diabetes	☐ seizures	_____
☐ asthma	☐ heart disease	☐ stroke	_____
☐ bleeding disorder	☐ high blood pressure	☐ tuberculosis	_____

Your present occupation _____

SOCIAL HIST OR Y

Are you a smoker ___ Yes ___No packs per day ___# of years ___ Do you drink alcohol? ___Yes ___No

Do you live _____Alone _____with spouse _____ with friends or family Do you participate in

Do you have stairs in your home? _____Yes _____No recreational drug use?

_____Yes _____No

Name: Date:

REVIEW OF SYSTEMS	*(Must circle Yes or No)*			If any yes answer, please explain below
General	Recent weight change	No	Yes	
Skin	Skin condition/cancer	No	Yes	
Head, eyes, ears, nose & throat (ENT)	Headaches	No	Yes	
	Dizziness / blacking out	No	Yes	
	Eye or hearing impairment	No	Yes	
	Sinus or throat trouble	No	Yes	
	Nosebleeds	No	Yes	
Neck	Thyroid disease	No	Yes	
	Enlarged glands	No	Yes	
Respiratory	Asthma	No	Yes	
	Difficulty breathing	No	Yes	
	Pleurisy or pneumonia	No	Yes	
Cardiovascular	Chest pain	No	Yes	
	Shortness of breath	No	Yes	
	Heart attack	No	Yes	
	High blood pressure	No	Yes	
	Blood clots in legs or lungs	No	Yes	
	Swelling of feet or legs	No	Yes	
	Poor circulation	No	Yes	
	Irregular heartbeat	No	Yes	
Gastrointestinal (GI)	Ulcer	No	Yes	
	Gallbladder	No	Yes	
	Hepatitis / liver trouble	No	Yes	
	Bleeding with bowel movements	No	Yes	
	Hemorrhoids	No	Yes	
	Hiatal hernia / reflux	No	Yes	
Genitourinary (GU)	Loss of urine / incontinence	No	Yes	
	Frequent urination	No	Yes	
	Burning, painful urination	No	Yes	
	Blood in urine	No	Yes	
	Kidney stones / kidney disease	No	Yes	
Gynecological (GYN)	Bleeding or other problem	No	Yes	
	Breast masses	No	Yes	
Musculoskeletal	Fractures or other injuries	No	Yes	
	Back or neck pain	No	Yes	
Neurological	Seizures or other conditions	No	Yes	
	Neuropathy	No	Yes	
	Stroke	No	Yes	
	Chronic pain	No	Yes	
	Fibromyalgia	No	Yes	
Psychological	Depression or other problems	No	Yes	
Hematological	Blood disorder or cancer	No	Yes	
	Excessive bleeding after surgery / dental work	No	Yes	

Initial Visit _____ Doctors Name: _____ Date: _____

HAVE THERE BEEN ANY CHANGES IN THE LIST ABOVE? Dr's. Initials: _____

Y **N** Comments: _____ Dr's. Initials: _____ Date: _____

Y **N** Comments: _____ Dr's. Initials: _____ Date: _____

Y **N** Comments: _____ Dr's. Initials: _____ Date: _____

Y **N** Comments: _____ Dr's. Initials: _____ Date: _____

Y **N** Comments: _____ Dr's. Initials: _____ Date: _____

Y **N** Comments: _____ Dr's. Initials: _____ Date: _____