



SEVEN SPRINGS ORTHOPAEDICS
& SPORTS MEDICINE

MEDICAL HISTORY

Today's Date: _____

PATIENT INFORMATION

Name: _____

Date of Birth: _____ Age: _____

Height: _____ Weight: _____

Referring Physician: _____

What are you being seen for today? *(include right or left body part)* _____

Injury Date: _____

Work Related: YES NO

Reported to Employer: YES NO

Attorney Name: _____

SYMPTOMS

Describe your symptoms: _____

Symptoms Are: MILD MODERATE SEVERE

Symptoms Are: CONSTANT or INTERMITTENT

Your other symptoms associated to this injury are:

None Fever Chills Weight Loss Tingling

Numbness Swelling Locking Giving Way

When did these symptoms begin? _____

What occurred for these symptoms to begin? _____

What makes you feel better? _____

What makes you feel worse? _____

Check all tests you have had regarding this injury:

X-rays MRI CT Scan Blood Work

Bone Density Bone Scan EMG

Facility/Hospital: _____ Date: _____

MEDICAL HISTORY/REVIEW OF SYSTEMS

Check all the health problems You have had:

Diabetes Heart Disease High Blood Pressure

Stroke Lung Disorder Sleep Apnea

Hepatitis Depression HIV

Asthma Cancer Headache

Anemia Chest Pain Shortness of Breath

Neurological Disorder Bleeding Problems

Weight Gain Weight Loss

Bladder/Bowel Problems High Cholesterol

Other: _____

Check all surgeries You have had:

Joint Surgery Spine Surgery Heart

Hysterectomy C-Section Tonsillectomy

Appendectomy Gallbladder

Other: _____

FAMILY HISTORY

Check all health problems blood members of your family have had and list that relative:

Arthritis _____ Osteoporosis _____

Cancer _____ Diabetes _____

Scoliosis _____ Heart Disease _____

Stroke _____ Bleeding Disorder _____

Blood Clots _____ Hypertension _____

Other: _____

SOCIAL HISTORY

Do you smoke? YES NO

Number of packs per Day: _____

Do you drink alcohol? YES NO

Number of drinks per day: _____

Have you been treated for, or do you currently have a problem with alcohol, illegal drug use, or prescription drug abuse? YES NO

MEDICATIONS

List the name, dosage, and frequency of all medications you are currently taking:

Medicine	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES

List the name of any drugs you are allergic to and what it does to you when taken:

LATEX ALLERGY

Internal Use Only:

Physician's Review _____ Date _____