**SPECIALTY ORTHOPAEDIC SURGERY** **PATIENT HISTORY FORM**

**DR SEAN J BRIMACOMBE** **DR FRANK W MOUSSA**

Please circle the appropriate response to the questions below.

Date _____

Name _____

Age _____ Date of Birth _____

Pharmacy_____Intersection_____

Pharmacy Phone_____Pharmacy Fax_____

Primary Care Doctor_____Referring Doctor_____

Name of person completing this form? _____

What primary language do you speak? _____

**Right Handed** or **Left Handed**

**Current Medical History:**

What is the problem you are being seen for today?_____

If you have pain, rate your pain on a scale of 1 - 10, ( 1 is very little to no pain and 10 is extreme pain)_____

Where is the pain located? (ie: L arm, R leg, back, pelvis)_____

Describe the pain? (ie: dull, throbbing, sharp, stabbing)_____

What makes your pain better?_____

What makes your pain worse? _____

Did you have an injury or trauma to this area? **YES** or **NO** **NOT SURE**

When did this problem start? _____

Is the problem **work related** or **vehicle related** **YES** or **NO**

How and when did the accident happen? _____

_____

Have you had any Treatment for this problem in the past? _____

_____

_____

Name of any previous treating providers for **this** problem? _____

_____

**SPECIALTY ORTHOPAEDIC SURGERY**

**Patient History Form**

**DR SEAN J BRIMACOMBE** **DR FRANK W MOUSSA**

Name _____

**Past Medical History:** Please check all previous illnesses or conditions below.

| | | |
|---|---|---|
| Heart problems | Lung problems | Diabetes or sugar in urine |
| High blood pressure | Liver problems | Thyroid problems |
| Circulation problems | Kidney/urine problems | Frequent infections |
| Stroke | Bleeding problems | HIV / AIDS |
| Seizure | Psychological/Psychiatric | Other |

**Please provide more information for any of the conditions or illnesses you checked above**

(if you checked any box above, please list the exact problem)

_____

_____

_____

_____

Have you ever been diagnosed with any type of cancer in the past? **Yes** or **No**

Please list any surgeries and the date of the surgery that you have had in the past.

(1)_____ (5) _____

(2) _____ (6) _____

(3) _____ (7) _____

(4) _____ (8) _____

Please list any Hospitalizations,include the reason and date of Hospitalizatic (not related to the above mentioned surgeries)

_____

_____

_____

_____

Do you have any problems with your HEARING or VISION? **Yes** or **No**

What is the problem you have with your Hearing or you Vision? _____

**SPECIALTY ORTHOPAEDIC SURGERY**

**Patient History Form**

**DR SEAN J BRIMACOMBE** **DR FRANK W MOUSSA**

Name _____

**Family History**

Are there any diseases or medical conditions which run in your family? (diabetes, stroke, heart disease)

| Problem | Family Member (i.e.: mother, father, sisters, brothers). |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**Current Medication** (include prescription, over - the - counter and herbals)

| Name of Medication | Dose | How often taken | Reason for taki | Length of time taken |
|---|---|---|---|---|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

Do you have any allergies OTHER than to MEDICATIONS? **Yes** or **No**

| Allergy | Reaction |
|---|---|
| _____ | |
| _____ | |

Do you have any allergies or reactions to any MEDICATIONS ? **Yes** or **No**

(List the name of the medication and the reaction is causes if you answer YES)

| Medication | Reaction |
|---|---|
| _____ | |
| _____ | |
| _____ | |
| _____ | |

**SPECIALTY ORTHOPAEDIC SURGERY**

**Patient History Form**

**DR SEAN J BRIMACOMBE** **DR FRANK W MOUSSA**

Name _____

**Work History**

If you are a student, what grade are you currently in? _____

What job have you held for the longest period of time? (including student or homemaker) _____

What is your current occupation? _____

Are you currently able to work? **Yes** or **No** **Not Applicable**

**Alcohol History:**
Do you drink alcoholic beverages ?

**Yes, currently** **I did but I quit** **Almost Never** **No Never Have**

On the average, how many drinks do you have a week? _____

If you did drink but have quit, when did you quit ? _____

**Tobacco History:**

Have you ever smoked cigarettes in your lifetime?

**Yes, currently** **I did but I quit** **Almost Never** **No Never Have**

How old were you when you first started smoking cigarettes? _____

On average, how many cigarettes do you smoke a day? _____

If you quit, when did you quit? _____

| **DO YOU** | Yes | No | Quit | Year Quit | Amount Used | Years Used |
|---|---|---|---|---|---|---|
| Chew tobacco | _____ | _____ | _____ | _____ | _____ | _____ |
| Snuff or Dip | _____ | _____ | _____ | _____ | _____ | _____ |
| Smoke a Pipe | _____ | _____ | _____ | _____ | _____ | _____ |
| Smoke Cigars | _____ | _____ | _____ | _____ | _____ | _____ |

Have you ever used ANY recreational (street) drugs?

**Yes, currently** **I did but I quit** **Almost Never** **No Never Have**

What drug ? _____

**SPECIALTY ORTHOPAEDIC SURGERY**

**Patient History Form**

**DR SEAN J BRIMACOMBE** **DR FRANK W MOUSSA**

**Review of Systems:**

Please check all problems that you are **having now**. If none apply to you, please check the box **None**.

**General:**
- fever/chills
- sweats
- change in sleep habits
- fatigue
- weight gain
- weight loss
- Other
- NONE

**Head & Neck**
- nosebleeds
- hoarseness
- sores in mouth or throat
- sore throat
- other
- NONE

**Cardiovascular:**
- chest pain
- fast heart beat
- other
- none

**Respiratory:**
- wheezing
- cough
- short of breath
- bloody phlegm/sputum
- other
- NONE

**Endocrine:**
- cold intolerance
- hot flashes
- other
- NONE

**Gastrointestinal:**
- yellow skin or eyes
- nausea/vomiting
- problems swallowing
- cramping/stomach pain
- change in appetite/diet
- indigestion
- reflux
- diarrhea
- constipation
- black stool
- blood in stool
- other
- NONE

**Genitourinary:**
- burning
- frequency
- blood in urine
- dribbling
- unable to control bladder
- other
- NONE

**Breast:**
- changes
- lumps
- nipple discharge
- other
- NONE

**Female Only:**
- unusual bleeding/discharge
- other
- NONE

**Male Only:**
- problems with passing urine
- enlarged prostate
- other
- NONE

**Musculoskeletal:**
(other than why you are here today)
- joint swelling
- joint/back pain
- stiffness
- trauma
- falls
- other
- NONE

**Skin:**
- open sore
- change in moles
- abnormal color
- rashes
- other
- NONE

**Neurological:**
- memory changes
- numbness/tingling
- dizziness/fainting
- weakness
- blurred vision
- headache
- ringing in ears
- seizures
- speech changes
- other
- NONE

**Psychological:**
- worried/anxious
- sad/depressed
- other
- NONE

**Hematology/Lymph:**
- abnormal bleeding
- prior transfusion
- easy bruising
- history of DVT/PE
- swelling in groin/armpit/neck
- other
- NONE