Orthopaedic Specialists of Dallas

Sports Medicine / Joint Replaceme nt
Shoulder Reconstruction / Podia try / Physical Therapy

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PATIENT MEDICAL HISTORY

PATIENT NAME: Patient Name PATIENT AGE: Age DATE: Report Date

REFERRING DOCTOR OR PERSON: _____
FAMILY DOCTOR: _____

ARE YOU RIGHT OR LEFT HANDED?: ☐ RIGHT ☐ LEFT

WHAT IS YOUR CURRENT JOB STATUS?: ☐ WORKING ☐ NOT WORKING ☐ LIGHT DUTY ☐ DISABLED

PLEASE DESCRIBE WHAT KIND OF WORK YOU PHYSICALLY DO:_____

DO YOU EXERCISE?: ☐ YES ☐ NO • HOW MANY TIMES PER WEEK: _____

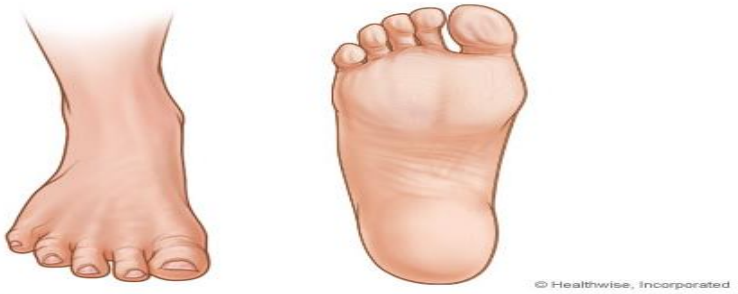
CHIEF COMPLAINT

WHAT PODIATRY PROBLEM ARE YOU SEEING THE DOCTOR FOR TODAY? WE NEED TO KNOW YOUR **SPECIFIC COMPLAINT/FOOT PROBLEM**.

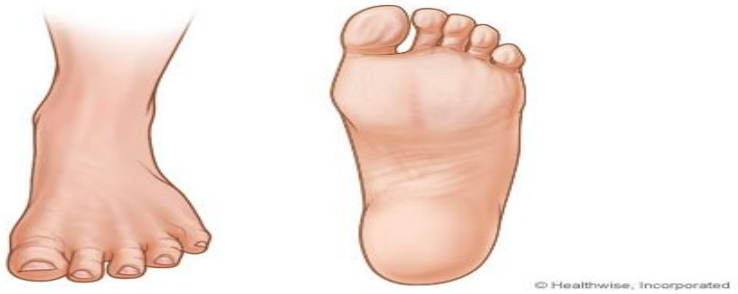
_____

_____

On these pictures, mark the area of your foot where the problem is.



Right foot



Left foot

Duration: _____
Onset:_____
Aggravating Factors (what makes it worse or better?):_____
Previous or Current Treatment?_____

Nature (circle all that apply):	**Location** (circle all that apply):	**Course** (circle all that apply):
Sharp	Left	Intermittent
Dull	Right	Constant
Achy	Ankle	Progressive
Burning	Foot	Varied
Stabbing	Toes: 1st, 2nd, 3rd, 4th, 5th	
Tingling		
Numbness		

CURRENT PROBLEM IS THE RESULT OF (CHECK ALL THAT APPLY):
☐ CAR ACCIDENT ☐ WORK RELATED ☐ INJURY ☐ OTHER
DATE OF ACCIDENT OR INJURY: _____/_____/_____
****EXACT DATE OF INJURY IS REQUIRED** IF YOU DO NOT REMEMBER THE EXACT DATE, PLEASE MARK A DATE THAT IS CLOSE TO THE DATE OF INJURY.** **This date will be used to process your claim. If you do not specify this, your insurance could deny your claim.
PLEASE DESCRIBE:

MEDICAL HISTORY

HAVE YOU EVER HAD OR CURRENTLY HAVE ANY OF THE FOLLOWING (PLEASE CHECK ALL THAT APPLY) :

☐ DIABETES ☐ ARTHRITIS ☐HIGH BLOOD PRESSURE ☐ HEART DISEASE ☐ GOUT ☐ VASCULAR DISEASES
☐ PACEMAKER/SURGICAL IMPLANTS ☐HEADACHES ☐KIDNEY PROBLEMS ☐ OPEN WOUNDS ☐ CURRENT INFECTIONS
☐ HERNIA ☐ SEIZURES ☐ METAL IN BODY ☐ CANCER/TUMOR ☐ THYROID PROBLEMS ☐ CVA/STROKE ☐ANXIETY
☐ PREVIOUS FRACTURES ☐ OSTEOPOROSIS ☐ DEPRESSION ☐ SUBSTANCE ABUSE ☐ HYPERSENSITIVITY TO HEAT/COL
☐ PRESENTLY PREGNANT ☐ HEPATITIS A ☐ HEPATITIS B ☐ HEPATITIS C ☐ HEART ATTACK ☐RAYNAUD'S ☐ WARTS ☐
TUBERCULOSIS ☐ HYPERTHYROID ☐ HYPOTHYROID ☐ HIGH CHOLESTEROL ☐ ANKLE SWELLING ☐ AUTOIMMUNE DISEASE
☐ BASAL CELL CARCINOMA ☐ BLEEDING DISORDER ☐ COPD ☐ CHARCOT FOOT ☐CIRCULATORY DISORDER
☐ RHEUMATOID ARTHRITIS ☐ SHORTNESS OF BREATHE ☐ LIVER DISEASE ☐ KIDNEY DISEASE ☐ MITRAL VALE PROLAPSE ☐
OTHER

PLEASE DESCRIBE ALL OF THE ABOVE THAT YOU HAVE CHECKED:
_____
_____
_____
_____
_____

HEIGHT: _____
WEIGHT:_____
SHOE SIZE: _____

PATIENT SURGICAL HISTORY

PATIENT NAME: Patient Name PATIENT AGE: Age DATE: Report Date

SURGICAL HISTORY

PLEASE LIST ALL THE SURGERIES YOU HAVE HAD IN THE PAST. PLEASE SPECIFY THE TYPE OF SURGERY AND THE YEAR THAT THE SURGERY WAS PERFORMED.

_____
_____
_____
_____

PHARMACY INFORMATION

PHARMACY NAME:

_____

PHARMACY PHONE:

_____

PHARMACY ADDRESS:

_____

** REFILLS WILL ONLY BE DONE WHEN REQUESTED THROUGH THE PHARMACY OR WHEN YOU COME IN FOR AN APPOINTMENT. WE WILL NOT REFILL MEDICATION IF YOU CALL US AT THE OFFICE. ALSO PLEASE ALLOW THE PHARMACY AT LEAST 1-2 DAYS FOR A REFILL REQUEST SO PLEASE CALL IN YOUR REFILL REQUEST TO THE PHARMACY WHEN YOU HAVE ABOUT 1-2 DAYS WORTH OF MEDICATION LEFT OVER. **

ALLERGIES TO MEDICATIONS (PLEASE LIST ALL MEDICATIONS THAT APPLY):

_____

When was your last flu shot (date)?_____
Have you received a Pneumonia vaccine (date)?_____

SOCIAL HISTORY

DO YOU HAVE CHILDREN: ☐ YES ☐ NO IF SO HOW MANY?: _____ DO YOU LIVE ALONE?: ☐ YES ☐ NO

DO YOU SMOKE?: ☐ YES ☐ NO IF SO HOW LONG?:_____ HOW MANY PACKS PER DAY?:_____

IF YOU QUIT SMOKING HOW LONG AGO DID YOU QUIT?:

_____

HOW LONG DID YOU SMOKE FOR?: _____ HOW MANY PACKS PER DAY?:

_____

DO YOU DRINK ANY ALCOHOLIC BEVERAGES? IF SO WHAT KIND AND HOW OFTEN?:

_____

_____

DO YOU HAVE ANY DRUG ABUSE OR ILLICIT SUBSTANCE ABUSE HISTORY?: ☐ YES ☐ NO IF SO, WHICH DRUGS AND HOW OFTEN?:

_____

MEDICATIONS

PATIENT NAME: Patient Name PATIENT AGE: Age DATE: Report Date

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING W/DOSES AND DIRECTIONS WHERE APPLICABLE

MEDICATION	DOSE	DIRECTIONS/COMMENTS
