NOVANT HEALTH

Orthopedics & Sports Medicine

Patient History Form

New Patient – No EH

Please Print

Last Name:		First Name:	DOB:
Hand Dominance ☐ R ☐ L		Height: _____ Feet ____ Inches	Weight: _____ lbs
Body Part being seen for today?	☐ R ☐ Both ☐ L	☐ Shoulder ☐ Elbow ☐ Wrist/Hand ☐ Hip ☐ Knee ☐ Ankle/Foot ☐ Other: _____	

History of Injury:

Did the problem result from a specific injury? ☐ Yes ☐ No		If yes, please explain:
Date of Injury: (If unknown, time frame of 1st symptoms)	____/____/____	
Did your problems begin following:	☐ Motor Vehicle Accident ~State: _____	☐ Work Injury
How did you become injured: (please explain)		
How long have you been experiencing these symptoms?	☐ Days: _____ ☐ Months: _____ ☐ Weeks: _____ ☐ Years: _____	

Have you had any of the following – as it relates to your current condition and visit today:

Test:	*Date:*	*Facility Name:*
☐ X-Ray		
☐ MRI		
☐ CT		
☐ EMG/NCV		

Allergies:

Are you allergic to **ANY** medications?	☐ No ☐ Yes	*List all allergies:*
Do you have a **Latex Allergy**?	☐ No ☐ Yes	

Surgical History:

Type of Surgery	*Date*	*Surgeon*

Past Medical History:

Please check if **you** currently, or ever previously, suffered from any of the following:

☐ Arthritis	☐ Diabetes	☐ High Lipids	☐ Polio	☐ Thyroid Disorder
☐ Asthma	☐ Gastritis	☐ Kidney Disease	☐ Psoriasis	☐ Ulcer Disease
☐ Blood Clots	☐ GI Bleed	☐ Liver Disease	☐ Reflux Disease	☐ Other (specify):
☐ Cancer	☐ Gout	☐ Lupus	☐ Rheumatic Fever	
☐ COPD	☐ Heart Disease/Attack	☐ Osteoporosis	☐ Seizure Disorder	
☐ Depression	☐ High Blood Pressure	☐ Peptic Ulcer	☐ Stroke	

Family History:

Please check if there is any history in your family of the following conditions and their relation:

Condition	*Relation*	*Condition*	*Relation*	☐ Other (specify):
☐ Blood Clots		☐ Kidney Disease		
☐ Cancer		☐ Osteoporosis		
☐ Diabetes		☐ Renal Failure		
☐ Heart Disease/Attack		☐ Rheumatoid Arthritis		
☐ Hypertension		☐ Stroke/Seizures		

Social History:

Alcohol Use:	☐ No ☐ Yes – How many per week? _____
Recreational Drug Use:	☐ No ☐ Yes – How often? ____
Tobacco Use:	☐ Never Smoker ☐ Former Smoker ~ Date Quit: _____ ☐ Current Some Day Smoker ~ # Years? ____ ~ Packs per day? _____ ☐ Current Every Day Smoker ~ # Years? ____ ~ Packs per day? _____
Smokeless Tobacco Use:	☐ Current User ☐ Former User ☐ Never Used

Medications:

Please list **all** medications you are currently taking. Please include **any** over the counter medications including, vitamins and supplements.

Medication	**Dosage**		**Medication**	**Dosage**		**Medication**	**Dosage**

Review of Systems:

Please check any/all that apply to your current health status:

General Health
☐ Recent Weight Change
☐ Chills
☐ Fever
☐ Weakness/Fatigue

Musculoskeletal
☐ Arthritis
☐ Rheumatoid Arthritis
☐ Muscle Aches
☐ Gout

Neurological
☐ Headaches
☐ Fainting/Blackouts
☐ Numbness/Tingling
☐ Dizziness

Eyes
☐ Vision Change
☐ Cataracts
☐ Glaucoma

Respiratory
☐ Shortness of Breath
☐ Wheezing/Asthma
☐ Frequent Cough

Psychiatric
☐ Depression
☐ Anxiety
☐ Mood Swing

Ear, Nose, Throat
☐ Loss of Hearing
☐ Ear Ache/Infection
☐ Ringing in Ear
☐ Hoarseness

Gastrointestinal
☐ Heartburn
☐ Acid Reflux
☐ Nausea/Vomiting
☐ Abdominal Pain

Endocrine
☐ Excessive Thirst/Hunger
☐ Heat/Cold Intolerance
☐ Hot Flashes

Cardiovascular
☐ Chest Pain
☐ Swelling in Legs
☐ Heart Murmur
☐ Palpitations

Skin
☐ Rash
☐ Ulcers
☐ Psoriasis
☐ Sores
☐ Abnormal Scars

Hematological
☐ Easy Bruising
☐ Easy Bleeding
☐ Anemia