St. Luke's Clinic - Orthopedics Health History

Patient Name:		**Date:**	
DOB:	**Age:**	**Hand Dominance** **Right Left**	**Pain Contract** **No Yes**
Height:	**Weight:**	**Pain Scale (0-10)**	**Location of Pain**

Medication Allergies: **Reaction:**

☐ Latex Allergy

Reason for Visit:

Is this a result of an injury? ☐ No ☐ Yes

Check One: ☐ Work-related ☐ Auto Accident ☐ Sports Injury ☐ other accident

Date of injury: _____ Is there litigation pending? ☐ No ☐ Yes

Describe how injury occurred:

Occupation: _____ **Employer:** _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Significant Other

Spouse or significant other's name: _____ DOB _____

MEDICATIONS

Name	Dose	Reason	Name	Dose	Reason
1)			5)		
2)			6)		
3)			7)		
4)			8)		

MEDICAL PROBLEMS (Heart Disease, Diabetes, Thyroid, Fibromyalgia, Blood Clots, ect.)

1)	6)
2)	7)
3)	8)
4)	9)
5)	10)

HOSPITALIZATIONS & SURGERIES

Type of surgery / Hospitalization	Year	Complications
1)		
2)		
3)		

FAMILY HISTORY

Problem	Relation	Problem	Relation
1)		3)	
2)		4)	

SOCIAL HISTORY

Drug Use:

☐ Never ☐ Previously (When and What) _____ ☐ Currently (What and how often) _____

Alcohol:	**Tobacco:**
☐ Never ☐ Social ☐ QTY: _____ Frequency: ____	☐ Never ☐ Stopped (When _____) ☐ Packs/day _____

Patient Name: _____

Review of Systems

Have you recently experienced any of the following: (Mark all that apply)

Cardiovascular	**Musculoskeletal**	**Constitutional**
☐ Chest Pain or Angina	☐ Muscle / Joint Weakness	☐ Chills
☐ Heart Attack / heart Failure	☐ Neck Pain / Stiffness	☐ Fatigue
☐ Heart Murmur / Arrhythmia	☐ Pain with walking	☐ Fever
☐ High Blood Pressure	☐ Pain with walking stairs	☐ Hormone Therapy
		☐ Immune Deficiency
Skin	**Neurological**	☐ Night Sweats
☐ Cold Sensitivity	☐ Dizziness	☐ Recent Weight Changes
☐ Rash	☐ Frequent Falls	☐ Steroid Use (oral or injected)
☐ Skin Ulceration / Breakdown	☐ Nerve Damage	
☐ Wound Healing Problems	☐ Numbness / Tingling in Extremities	**GI / GU**
	☐ Paralysis	☐ Difficulty Urinating
Respiratory		☐ GI Bleeds
☐ Asthma or Wheezing	**HEENT**	☐ Incontinence
☐ Cough	☐ Frequent Headaches	☐ Nausea / Vomiting
☐ Pneumonia or Bronchitis	☐ Hearing Loss	☐ Ulcers
	☐ Mouth or Dental Infections	☐ Urinary Tract Infection
Endo / Hema / Allergy	☐ Vision Changes (blurred, double)	
☐ Anemia / Blood Deficiency		**Psychiatric**
☐ Bleeding Disorders		☐ Depression
☐ Blood Clots		☐ Memory Loss
☐ Environmental Allergies		☐ Suicidal Thoughts
☐ Nose Bleeds		

Learning Assessment
Do you have any barriers to learning? (Check all that apply)

☐ Reading ☐ Language ☐ Visual ☐ Hearing ☐ Physical

☐ Emotional ☐ Cognitive ☐ Financial ☐ Spiritual ☐ Cultural

☐ Other: _____

How do you prefer to learn new concepts?
(Check all that apply)

☐ Listening ☐ Reading ☐ Demonstration ☐ Pictures / Video

☐ Other _____

Primary Language Spoken:

Is an interpreter required for your appointments?

☐ No

☐ Yes