Texas Joint Institute

Patient Health History

Patient Name:_____Age:_____Height:_____Weight:_____[ ] Female [ ] Male

Which hand do you eat/write with? [ ] Left [ ] Right [ ] Both

Physician Information

Primary care physician name: _____ Phone number: _____
Referring physician name: _____ Phone number: _____

What is the main reason for your visit today: [ ] Pain [ ] Numbness [ ] Weakness [ ] Swelling
[ ] Stiffness [ ] other:_____Did you bring x-rays: [ ] Yes [ ] No

What Body Part is involved? Please mark in the table below:

Shoulder [ ] R [ ] L	Elbow [ ] R [ ] L	Hand [ ] R [ ] L	Pelvis [ ] R [ ] L	Knee [ ] R [ ] L	Foot [ ] R [ ] L
Arm [ ] R [ ] L	Wrist [ ] R [ ] L	Finger [ ] R [ ] L T 2 3 4 5 - ☐☐☐☐☐ circle	Hip [ ] R [ ] L	Ankle [ ] R [ ] L	Toe [ ] R [ ] L T 2 3 4 5 - ☐☐☐☐☐ circle

How long ago did your symptoms start?_____Days_____Weeks_____Months_____Years
Have you had a problem like this before? [ ] Yes [ ] No

In this section, check the **ONE BOX** which best describes how your problem started. Then answer the questions below the box you checked. Use as much space to the right as needed.

Comments:

[ ] **No Injury** (Onset was: [ ] Gradual [ ] Sudden)
Why do you think it started?
[ ] **Injury** ([ ] Sport [ ] Accident-**Not Auto or Work**)
Date:_____Where and how did it happen?

What Sport? _____
[ ] **Injury at Work**: Date: _____

From a [ ] Lift [ ] Twist [ ] Fall [ ] Bend [ ] Pull [ ]Reach

On a Scale of 0-10 (10 is the worst) how ***severe*** is your pain? (Circle) ☐☐☐☐☐☐☐☐☐☐☐
0 1 2 3 4 5 6 7 8 9 10
What is the quality of the pain? [ ] Sharp [ ] Dull [ ] Stabbing [ ] Throbbing [ ] Aching [ ] Burning

The pain is: [ ] Constant [ ] Comes and Goes Does your pain wake you from sleep? [ ] Yes [ ] No

Do you have any of the following? [ ] Swelling [ ] Bruising [ ] Numbness [ ] Tingling [ ] Weakness

Since my problem started, it is: [ ] Getting Better [ ] Getting Worse [ ] Unchanged

What makes your symptoms ***worse***? [ ] Standing [ ] Walking [ ] Lifting [ ] Exercise [ ] Twisting

[ ] Lying in bed [ ] Bending [ ] Squatting [ ] Kneeling [ ] Stairs [ ] Sitting [ ] Reaching Overhead

[ ] Reaching Behind your back

What makes your symptoms ***better***? [ ] Rest [ ] Elevation [ ] Ice [ ] Heat [ ] Other: _____

What Medications are you currently taking for *this problem*? _____

Have you had any of these treatments for *this problem*? [ ] Injection [ ] Brace [ ] Physical Therapy

[ ] Cane/Crutches

What Scans/Tests have you had for *this problem*? [ ] X-Rays [ ] MRI [ ] CT Scan [ ] Bone Scan

[ ] Nerve Test (EMG)

Current Work Status? [ ] Regular [ ]Light Duty (how long?_____) [ ] Not working due to this problem
[ ] Disabled [ ] Retired [ ] Student [ ] Unemployed

Occupation:_____

When is the last date you worked at your job? _____

Social History:

Do you use tobacco? [ ]Yes [ ]No Packs/day____ Alcohol Use? [ ]None [ ]Social [ ]Daily [ ] Frequently

Illegal Drug Use? [ ] Yes [ ] No If yes, what type? _____

Who lives with you? [ ] Mother [ ] Father [ ] Husband [ ] Wife [ ] Children [ ] Other

Review of Systems:

Current Symptoms: [ ] None

CONST: [ ] Chills [ ] Fever [ ] Night Sweats

SKIN: [ ] Open Sores

EYE: [ ] Blurred Vision [ ] Double Vision [ ]Eye Pain

RESP: [ ] Chronic cough [ ] Shortness of Breath

C-VASC: [ ] Chest Pain [ ] Irregular Heartbeat

GU: [ ] Painful Urination [ ] Trouble Starting Urination

GI: [ ] Abdominal Pain [ ] Dark Black Stool [ ] Vomiting Blood [ ]

Blood in Stool **M/S:** [ ] Pain in Joints [ ] **Pain in Muscles** [ ] Morning

Stiffness [ ] Swollen Joints **PSYCH:** [ ] Depression [ ] Anxiety [ ]

Hearing Voices

Neuro: [ ] Headaches [ ] Dizziness [ ] Poor Coordination [ ] Numbness

Past Medical History:

Have you ever been diagnosed with any of the following conditions? Check all that apply [ ] None

[ ] Asthma [ ] Stroke [ ] Heart Attack (when?_____) [ ] High Cholesterol

[ ] Kidney Failure [ ] Heart Failure [ ] Cancer (location?_____) [ ] High Blood Pressure

[ ] Ulcers [ ] Hepatitis [ ] Seizures [ ] HIV [ ] Emphasyema/COPD

[ ] Diabetes [ ] Blood Clots(DVT) or PE [ ] Thyroid Problem [ ] Bipolar Disorder

[ ] Liver Disease Notes/Other: _____

Allergies: Do you have any ***Allergies*** to any medications? **[ ]** Yes **[ ]** No If Yes, please list below: Medication Reaction

Family History: What illnesses have been in your family? List illness and family member affected [ ] None

Past Surgical History: What Operations have you had (for any reason)? **[ ]** None

Past Hospitalizations: [ ] None

New Diagnosis: [ ] None

UPDATED MEDICATIONS			
Name	Dose / Strength	Frequency	Prescribing Physician
Example: Metoprolol	*40 mg*	*2 tabs in a.m. & 1 tab in p.m.*	*Dr. Jon Smith (Internal Medicine Doctor)*

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge. Patient (Or Responsible Party) Signature: Date: