Dignity Health.
Mercy Orthopedic, Spine & Hand Center

Mercy Orthopedic, Spine & Hand Center
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Patient Health History

Name: (LAST)_____ (FIRST)_____ (MIDDLE)_____

Today's Date: _____

Date of Birth:_____ Age:_____ Gender: ☐Male ☐Female

☐Right-handed ☐Left-handed

Were you referred to our office by friend, relative, current treating physician or other? ☐Yes ☐No

Were you treated as an emergency by one of our doctors prior to this visit? ☐Yes ☐No

Doctors name: _____

Primary Care Physician (PCP) Name: _____

CHIEF COMPLAINT: (REASON FOR VISIT) _____

Date of injury:_____ Where did injury occur: _____

Is this job related? ☐Yes ☐No If yes, describe how it occurred: _____

Prior industrial injuries? ☐Yes ☐No If yes, describe how it occurred: _____

Prior injury area of complaint? ☐Yes ☐No If yes, describe injury:_____

Job Title: _____ Length of employment in this capacity: _____

HISTORY OF PRESENT ILLNESS / INJURY:

(PLEASE **CHECK** ANY OF THE FOLLOWING THAT BEST DESCRIBE YOUR PROBLEM)

Area(s) of Pain:

☐Right ☐Left ☐Hand ☐Wrist ☐Elbow ☐Shoulder

☐Bilateral ☐Hip ☐Knee ☐Back ☐Neck ☐Other:_____

Severity of Pain:

☐0-1 No pain ☐2-3 Mild pain ☐4-5 Discomforting ☐6-7 Distressing ☐8-9 Intense ☐10 Unbearable

Quality of Pain:

☐Sharp ☐Dull ☐Throbbing ☐Burning ☐Aching

Duration of Pain:

☐Intermittent ☐Constant ☐Minutes

Timing of Pain (makes pain worse):

☐With Exercise ☐Activity ☐Nightly ☐At rest ☐Sitting ☐Walking

Modifying factors (makes pain better):

☐Rest ☐Heat ☐Cold ☐Elevation ☐Standing ☐Sitting ☐Walking

Context of Pain:

☐Worsening ☐Recurrent ☐Improving

Associated signs:

☐Bruising ☐Numbness ☐Tingling ☐Buckling ☐Locking ☐Weakness ☐Dislocating

PRIOR TREATMENTS FOR THIS CONDITION: (PLEASE **CHECK** ALL THAT APPLY)

☐None

☐Nonsteroidal anti-inflammatory drugs (Ibuprofen, Aleve, Celebrex, etc)

☐Narcotic pain medications (Vicodin, Norco, Percocet, Tramadol, Oxycontin, Fentanyl patch, etc.)

☐Other medications (Neurontin, Cymbalta, Amitriptyline, Steroids, Muscle Relaxants, etc): which ones? _____

☐Physical Therapy (hand, wrist, shoulder, knee, etc): which ones? _____

☐ Injections (hand, wrist, shoulder, knee, etc): which ones? _____

☐Chiropractic: name of doctor: _____

☐Pain management specialist: name of doctor _____

☐Other Treatments (acupuncture, homeopathic, herbal, other): _____

☐Surgery (include specific details in past surgical history, page 3)

☐Fractures: _____

☐Have you ever had local/general anesthesia: ☐Yes ☐No

Any problems with anesthesia: ☐Yes ☐No If yes, describe problem:_____

Spine Patients **ONLY**:

☐Spinal injections (epidural, facet joint, other): type of injection _____

Did pain get better after injection? ☐Yes ☐No _____

How long did pain relief from injection last? _____

☐Spinal Surgery: List type of surgery, when it was done and name of surgeon:_____

PAST MEDICAL HISTORY:

Last physical exam: _____

Other specialty physicians:_____

ILLNESSES: Please place a checkmark if you have or have had any of the following illnesses:

☐Acid Reflux	☐Depression	☐Irregular Heart Beat	☐Peripheral Vascular Disease
☐Alcoholism	☐Epstein Barr	☐Keloids	☐Phlebitis
☐Alzheimer's	☐Fibromyalgia	☐Kidney Problems	☐Rheumatoid Arthritis
☐Anemia	☐Glaucoma	☐Liver	☐Scoliosis
☐Aneurysm	☐Gout	☐Lupus	☐Seizures
☐Angina	☐Heart Disease	☐Migraine	☐Skin Problems
☐Arthritis	☐Heart Murmur	☐Mitral Valve Prolapse	☐Spinal Stenosis
☐Asthma	☐Heart Pacemaker	☐Myelopathy	☐Spondylolisthesis
☐Bleeding Disorder	☐Hepatitis	☐Myocardial Infarction	☐Stomach Ulcer
☐Blood Clot	☐Herniated Disc	☐Nervous Condition	☐Stroke
☐Broken Bones	☐Hiatal Hernia	☐Osteoarthritis	☐Tuberculosis

☐Cancer
☐Cerebral Palsy
☐Currently Pregnant
☐Degenerative Disc
☐High Blood Pressure
☐High Cholesterol
☐HIV
☐Osteoporosis
☐Parkinson's
☐Peptic Ulcer
☐Valley Fever
☐Other Illnesses _____
☐No illnesses

PRIOR SURGERIES: Please place a check mark if you have had procedures on any body part listed. Please include the specific procedure, right/left or bilateral and approximate date, in the space provided.

☐Abdominal
☐Amputation
☐Ankle
☐Appendectomy
☐Arm
☐Back Surgery
☐Biopsy
☐Bladder
☐Bowel
☐Breast
☐Cardiac (Heart)
☐Carotid
☐Carpal Tunnel
☐Cataracts
☐Dental
☐Dermatology
☐Discectomy
☐Elbow
☐Feet
☐Finger
☐Fracture
☐Gallbladder
☐Hand
☐Head/eyes/ears/nose/throat
☐Heart Stent
☐Hernia
☐Hip
☐Hip Replacement
☐Kidney
☐Knee
☐Knee Arthroscopy
☐Knee Replacement
☐Laminectomy
☐Liver
☐Lungs
☐OB/Gyn (Female)
☐Pacemaker
☐Parathyroidectomy
☐Plastic Surgery
☐Prostatectomy
☐Rectal
☐Shoulder
☐Shoulder Replacement
☐Spinal Fusion
☐Spleen Removed
☐Stomach
☐Testicle
☐Thyroid
☐Tonsillectomy
☐Trachea
☐Ulcers
☐Vasectomy
☐Vertebral
☐Disc Replacement
☐Wrist

☐Other Surgeries _____
☐No past surgical history

MEDICATIONS: Prescription, over-the-counter, vitamins and herbals.

Name	Strength

ALERGIC/IMMUNOLOGIC: List food/environmental allergies.

☐No known allergies ☐Latex sensitivity/allergy

Substance	Effect

FAMILY HISTORY: Please place a check mark if there is a family history of the following:

Family Member: Father – F, Mother – M, Sister – S, Brother – B, Extended Family - E

☐Alcoholism ___ ☐Cancer-Breast ___ ☐Diabetes ___ ☐High Cholesterol ___

☐Alzheimer's ___ ☐Cancer-Colon ___ ☐Gout ___ ☐Kidney Problems ___

☐Arthritis ___ ☐Cancer-Other ___ ☐Heart Disease ___ ☐Malignant Hyperthermia _

☐Bleeding Disorder ___ ☐Cancer-Prostate ___ ☐High Blood Pressure ___ ☐Spine Problems ___

☐Other family history of ___ ☐No family history

SOCIAL HISTORY:

☐Work in the home ☐Student ☐Education (years and degrees):_____

☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

Do you live alone? ☐Yes ☐No

Do you exercise? ☐Daily ☐Weekly ☐Monthly ☐Rarely ☐Never

Hobbies:_____

What types of exercise and /or sports:_____

Are you on a special diet? ☐Yes ☐No Describe:_____

Drink alcohol? ☐Yes ☐ No ☐Formerly If "yes" or "formerly", how often?_____

Do you smoke? ☐Yes ☐No ☐Formerly If "yes" or "formerly", how often?_____

Do you use illegal drugs? ☐Yes ☐No If "yes", which one(s)_____

Are you adopted? ☐ Yes ☐No

Women: Are you pregnant? ☐Yes ☐No Last menstrual cycle: _____

REVIEW OF SYSTEMS: Please indicate if you have any of the following conditions or symptoms

Cardiovascular

☐Chest pain

☐Elevated Blood Pressure

☐Irregular Heartbeat/Palpitations

☐Leg Edema

☐Syncope

Constitutional

☐Chills

☐Decreased Appetite

☐Fatigue

☐Fever

☐Night Sweats

☐Weight loss

Metabolic/Endocrine

☐Adrenal Insufficiency

☐Diabetes (Insulin Dependent)

☐Diabetes (Non-insulin Dependent)

☐Osteoporosis

☐Thyroid Disorder

GI – Gastrointestinal

☐Black Tarry Stools

☐Bowel Incontinence

☐Constipation

☐Diarrhea

☐Jaundice

☐Nausea

☐Rectal Bleeding

☐Vomiting

GU – Genitourinary

☐Difficulty Urinating

☐Frequently Urinating

☐Kidney Stones

☐Sexual Dysfunction

☐Urinary Incontinence

Head/Eyes/Ears/Nose/Throat

☐Blurry Vision

☐Difficulty swallowing

☐Double vision

☐Hearing Loss

☐Hoarse Voice

☐Nose Bleeds

☐Ringing in ears

☐Wears glasses/contacts

Hematologic/Lymphatic

- ☐Anemia
- ☐Bleeding
- ☐Bruising
- ☐Node swelling
- ☐Slow to heal after cuts

Skin

- ☐Chronic wounds
- ☐Rash
- ☐Skin Lesions
- ☐Ulcerations

Musculoskeletal

- ☐Back pain
- ☐Difficulty walking
- ☐Fibromyalgia
- ☐Joint pain
- ☐Muscle Cramping
- ☐Muscle weakness
- ☐Neck pain

Neurologic

- ☐Dizziness
- ☐Headaches
- ☐Numbness
- ☐Seizures
- ☐Stroke
- ☐Tingling

Psychiatric

- ☐Anxiety
- ☐Confusion
- ☐Depression
- ☐Insomnia
- ☐Memory Loss
- ☐Suicidal Ideation

Respiratory

- ☐Cough
- ☐Hemoptysis
- ☐Orthopnea
- ☐Shortness of Breath
- ☐Wheezing