Performance Orthopedics
10448 Old Olive Street Road Suite 200
Creve Coeur, MO 63141
Phone: 314-597-888 Fax: 314-447-9559
www.performanceorthopedicsstl.com

Medical History Form

Name: _____DOB:_____Age:_____Sex:_____

Address:_____

_____

SSN:_____

Phone #:_____

Today's Date:_____

Height_____Weight_____Recent increase or decrease_____

Left or Right- handed_____Body part affected_____

Quality of discomfort: Intermittent Constant Other_____

Type of discomfort: Severe Moderate Mild Other_____

DURATION: How long has this been a problem_____

Date of injury_____Description of injury_____

Please circle the activities that make pain worse:

Sitting Standing Lying Walking Lifting Bending Coughing Sneezing

Stairs Pushing Pulling Other_____

Please list any activities that make your pain less_____

Does your pain interfere with sleep?_____

Has any other treatment helped control your symptoms?_____

Does the joint (please circle) catch lock or seize up swell pop snap grind shift pop out of joint give out

Do you have numbness: Lt leg Rt leg Lt arm Rt arm

Do you have weakness: Lt leg Rt leg Lt arm Rt arm

Loss of Control: urination defecation erection

Has ability to walk distances been limited?____Distance you can walk before having to stop_____

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Review of Systems: (recent or current conditions):

Weight change	Hearing changes	Shortness of breath	Urinary bleeding
Fever/Chills	Ear pain/ringing	Cough	Frequent headaches
Night sweats	Nosebleeds	Nausea/vomiting/seizures	Numbness
Poor appetite	Hoarseness	Stomach pain	Weakness
Rash	Difficulty swallowing	Frequent Diarrhea	Backache
Insomnia	Tooth/gum trouble	Frequent constipation	Musculoskeletal
Depression	Chest pain	Blood in stool	Joint/Limb pain/Swelling
Anxiety	Abnormal heartbeat	Incontinence	Lump masses
Visual changes	Blackouts	Urinary frequency	Woman only: Pregnant

If you circled any of the above, please explain:_____
_____

Past Medical History: (Circle)

Hypertension (high blood pressure)	Diabetes
Elevated Cholesterol	Heart Disease
Arthritis	Cancer

Other:_____

Past Surgical History: (Please indicate each procedure and yr performed)
_____
_____

Medications: (Name and Dose)
_____
_____

Allergies:_____

Social History:

Are you now or have you ever been treated for an emotional or psychological order?_____
Do you smoke?_____Packs/day_____
Do you consume alcohol?_____Amount/day_____
Recreational drug use?_____Amount_____
Marital status (please circle) Single Married Divorced Widowed
Employment Status (list/describe job if employed)_____
Referred by:_____
Who is your primary care physician?_____

Family History:(circle)

Hypertension	Mother	Father	Sibling	Grandparent
Cancer	Mother	Father	Sibling	Grandparent
Diabetes	Mother	Father	Sibling	Grandparent
Arthritis	Mother	Father	Sibling	Grandparent
Heart Disease	Mother	Father	Sibling	Grandparent

Other:_____

List all diagnostic studies you have had for this condition along with date and place the study was performed. (X-ray, MRI, Myelogram, CT Scan, Bone Scan, EMG/NCV, ect.)

1._____2._____3. _____

Patient Signature_____Date:_____