Baylor Scott & White Orthopedic Trauma Associates – New Patient Health History

Please complete entire form; information does not transfer from Baylor Healthcare System

First Name & Middle Initial:	Last Name	Today's Date:
DOB:	Reason for Visit:	Date of Onset:
Work Related injury? Yes No	Treatment received: Surgical / Non-surgical	
Primary Care Physician/ Referring Physician:	PCP/Referring Physician Phone#:	PCP/Referring Physician Address:
Pharmacy:	Pharmacy Phone:	Pharmacy Address:

Weight	Lbs
Height	Ft. In.

Allergies

What are you allergic to? Example: medicines, iodine, latex	What happens to you? Example: Rash, dizzy, nausea

Medications (Please list any medications, prescription, over the counter and vitamins)

Name of Medicine	How much do you take? *EXAMPLE*: 500 mg 2 drops 25 mcg 1 tablet 60 mg	How do you take it? *EXAMPLE*: By mouth	How often do you take it? *EXAMPLE*: 1 time a day	Why do you take it? *EXAMPLE*: blood pressure

Medical History

Alcoholism	Yes No	Fractures	Yes No	Kidney disease	Yes No
Anesthetic Complications	Yes No	Gout	Yes No	Liver disease	Yes No
Autoimmune Disease	Yes No	Heart Disease	Yes No	Lung Disease	Yes No
Cancer	Yes No	Hep C	Yes No	Osteoarthritis	Yes No
Cerebral Palsy	Yes No	HIV/AIDS	Yes No	Rheumatoid Arthritis	Yes No
Clotting Disorder	Yes No	High Cholesterol	Yes No	Smoking	Yes No
DVT (Blood Clot)	Yes No	High Blood pressure	Yes No	Stroke	Yes No
Diabetes Mellitus	Yes No	Infectious Disease	Yes No	Thyroid Disease	Yes No
If "yes", please explain:					

Surgical History

Ankle Surgery	Yes No	Foot Surgery	Yes No	Lumbar Spine Surgery	Yes No
Back Surgery	Yes No	Hand Surgery	Yes No	Shoulder Surgery	Yes No
Bariatric Surgery	Yes No	Heart Surgery	Yes No	Spinal Fusion	Yes No
Carpal Tunnel Release	Yes No	Knee Arthroscopy	Yes No	Spine Surgery	Yes No
Cervical Spine Surgery	Yes No	Knee Surgery	Yes No	Wrist Surgery	Yes No
Elbow Surgery	Yes No				
Other Surgical History					

Family History

	Anesthesia Problems	Arthritis	Autoimmune Disease	Cancer	Clotting Disorder	Deep Vein Thrombosis	Diabetes Mellitus	Gout	Heart Disease	Hepatitis	HIV	High Cholesterol	High Blood Pressure	Kidney Disease	Liver Disease	Lung Disease	Osteoporosis	Ovarian Cancer	Stroke	Thyroid Disease
Mother																				
Father																				
Other																				
Details:																				

Social History – Please circle as appropriate

Alcohol Use Current/Former User?	Yes No	*If Yes:* # of Drinks/Week	*How often ?* Never 2-3/ weekly Monthly 4 or more a week	
Drug Use Current/Former User?	Yes No	*# of Uses/Week*	*What type of drugs were used?*	
Tobacco Use Current/Former User?	Yes No	*Daily Use?* Yes No	*Type:* Cigarettes E-cigs Cigars Snuff Chew Smokeless	*How many years of use?*
Employment status	Employed Retired Disabled		Other:	
Marital Status:	Married Widowed Single Divorced/ Separated		If you have children, # of children:	

Review of Systems

☐ Weight Loss/Gain	☐ Night Sweats	☐ Fever
☐ Double Vision	☐ Blind Spots	☐ Ringing in Ears
☐ Vertigo/Dizziness	☐ Shortness of Breath: ☐ Chest Pain ☐ At Rest ☐ With Activity	☐ Abdominal Pain ☐ Incontinence (Loss of Bowel Movements) ☐ Incontinence (Loss of Control of Urine) ☐ Sexual Problems
☐ Pressure Sores	☐ Rash	☐ Easy Bruising
☐ Bleeding Disorder	☐ Heat/Cold Intolerance	☐ Diabetes
☐ Anxiety/Depression ☐ Difficulty Sleeping ☐ Falls	☐ Irritability ☐ Cognitive Problems ☐ Spasm of Muscles	☐ Lack of Concentration ☐ Difficulty Speaking ☐ Behavioral Problems
☐ Stress in Personal Life	☐ Any chance that you are pregnant?	

Describe in detail any checked boxes above:

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