Today's Date:

Texas Orthopedic Partners

4401 Coit Road, Suite 203 Frisco, Texas 75035 Phone: (469) 800-7070 Fax: (469) 800-7080

Patient New Problem—Medical History Form

Patient Name: DOB:

Problem History and Background

Are you right or left handed (please circle one)	
What is your main complaint?	What is the date of your injury? How long has this complaint been present?
Please indicate your current pain level 0 1 2 3 4 5 6 7 8 9 10	What makes your pain **better**? Rest Heat Cold Medication Exercise Other_______________
What words best describe how the pain feels? Sharp Burning Shooting Deep Stabbing Throbbing Aching Pressure Dull Tingling Other__________________	What makes your pain **worse**? Rest Heat Cold Medication Exercise Other_______________

Constitutional

Chills
Weight Loss
Malaise/Fatigue
Diaphoresis (Excessive Sweating)
Weakness

Skin

Rash
Itching

HENT

Headaches
Hearing Loss
Tinnitus
Ear Pain
Ear Discharge
Nosebleeds
Congestion
Stridor– (Vibrating Noise when breathing)
Sore Throat

Eyes

Blurred Vision
Double Vision
Photophobia (Sensitivity to light)
Eye Pain
Eye Discharge
Eye Redness

Cardiovascular

Chest Pain
Palpitations
Orthopnea
Claudication (cramping pain caused by obstruction in arteries)
Leg Swelling
PND– attacks of shortness of breath and coughing at night)

Respiratory

Hemoptysis-(Coughing up blood)
Sputum Production– (Excessive mucus)
Shortness of Breath
Wheezing

Gastrointestinal

Heartburn
Nausea
Vomiting
Abdominal Pain
Diarrhea
Constipation
Blood in Stool
Melena– (Dark, Sticky stool)

Genitourinary

Dysuria– (Painful urination)
Urgency
Frequency
Hematuria– (Blood in urine)
Flank Pain

Musculoskeletal

Myalgias- (Muscle pain)
Neck Pain
Back Pain
Joint Pain
Falls

Endo/Hem/Aller

Easy Bruise/bleed
Environmental Allergies
Polydipsia-(Great feeling of thirst)

Neurological

Dizziness
Tingling
Tremor
Sensory Change
Speech Change
Focal Weakness
Seizures
LOC– (Loss of Consciousness)

Psychiatric

Depression
Suicidal Ideas
Substance Abuse
Hallucinations
Nervous/Anxious
Insomnia
Memory Loss

I attest that everything stated here is true to the best of my knowledge: **Patient Signature:**______________________ **Date:**________

I have personally reviewed this form with the patient: Physician Signature:_____________________________ **Date:**_________