

GREATER PITTSBURGH ORTHOPAEDIC ASSOCIATES

PATIENT PRESENT INJURY / ILLNESS FORM

Full Name: _____ Date of Birth: _____ Today's Date: _____

Street Address: _____ City _____ State _____ Zip _____

Phone# _____ Work# _____ Cell# _____

E-mail: _____ SS# _____

Emergency contact other than someone living with you _____ Phone # _____

Closest family member _____ Phone # _____

Chief Complaint _____ **Right** _____ **Left** _____

Why are you seeing the doctor today? _____

Describe injury/present illness in detail _____

How long has it been bothering you? _____

Current problem is the result of a(n): **Check** all that apply

_____ Car Accident _____ Work Accident _____ Accident _____ Other _____ Date of Accident _____

Describe how the accident happened _____

Are you currently working? _____ If no, last day worked _____

Hand dominance _____ Right _____ Left _____ Ambidextrous _____

Referring Physician Name _____ Phone # _____

Address _____

Primary Care Physician _____ Phone # _____

Medication	Dose	Medication	Dose

Pharmacy name _____ Phone # _____

Pharmacy address _____

Allergies:	Do you have any Allergies? _____
	(adhesive tape, drugs, dyes, food, injectable medication, iodine, latex, metal, shellfish, steroids, etc.)

Are you taking any herbs or vitamin or diet pills supplements? _____ if yes, describe _____

Do you take aspirin daily? _____

Review of Systems - Are you currently having or have you had problems with:

	Circle One			Circle One	
Blackout/fainting	No	Yes	Headache/dizziness	No	Yes
Bladder/bowel movement	No	Yes	High blood pressure	No	Yes
Bleeding or clotting problems	No	Yes	Lower back pain	No	Yes
Changes in skin color/texture	No	Yes	Lungs, Breathing/cough	No	Yes
Chest pain/palpitation	No	Yes	Muscle/bone/joint pain	No	Yes
Digestion	No	Yes	Numbness/tingling	No	Yes
Ears, Nose, Throat	No	Yes	Swelling/dislocation - extremity	No	Yes
Eyes/visual disturbance	No	Yes	Weight loss or gain	No	Yes
Fever/chills/sweats/fatigue	No	Yes	<i>Describe all yes answers in space below:</i>		

Patient Signature: _____ **Date:** _____

Reviewed By: _____ **MD Date:** _____

Physician's use only:

Physician _____ DX _____

Procedure _____ Date of surgery _____

Physical Exam Done _____ **Date** _____

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PATIENT HEALTH HISTORY FORM

Full Name: _____ Male _____ Female _____ Today's Date: _____
 SS# _____ Date of Birth _____ Age _____ Height _____ Weight _____

Policy Holder's Information

Name of Insurance Policy Holder _____
 Policy Holder's Date of Birth _____ Policy Holder's Social Security # _____
 Policy Holder's Address _____
 Policy Holder's e-mail address _____
 Policy Holder's Phone # _____ Policy Holder Employer _____

Your Past Medical History

Arthritis	No	Yes	Infections	No	Yes
Asthma	No	Yes	Kidney Disease	No	Yes
Blood Transfusion _____ year	No	Yes	Liver Disease	No	Yes
Cancer	No	Yes	Neurological Disorder	No	Yes
Diabetes (on insulin?)	No	Yes	Polio	No	Yes
Epilepsy	No	Yes	Psychiatric Problem	No	Yes
GI Disease (Ulcers)	No	Yes	Respiratory Disease / TB	No	Yes
Heart Disease	No	Yes	Sleep Apnea	No	Yes
Hepatitis	No	Yes	Stroke	No	Yes
HIV or other Immune deficiency Hepatitis	No	Yes	Thyroid Disease	No	Yes
Hypertension (high blood pressure)	No	Yes	Vascular Disease	No	Yes

Surgeries / Hospitalizations	Year	Complications

Have you ever had general anesthesia? No Yes
 Have any problems with anesthesia? No Yes Describe: _____

Your Family History

Please list Family History of Above Diseases: (ie: diabetes, heart disease, neuromuscular, etc)

Grandmother (mom's or dad's)
Grandfather (mom's or dad's)
Mother
Father
Sister / Brother

Have any family members had problems with anesthesia? No Yes Describe: _____

Your Social History

____ Employed (occupation _____) Full-time _____ Part-time _____
 Place of employment _____ Phone # _____
 _____ Student _____ Retired _____ Homemaker
 _____ Single _____ Married _____ Divorced _____ Separated _____ Widowed
 Children? _____ No _____ Yes # _____
 Do you live alone? _____ No _____ Yes _____ One story _____ Two story / steps
 Exercise? _____ Daily _____ Weekly _____ Monthly _____ Rarely _____ Never
 What type of exercise? _____
 Recreational Activities? _____
 Drink alcohol? _____ Daily _____ 1-2 x/week _____ 1-2 x/month _____ 1-2 x/year
 History of substance abuse? _____ No _____ Yes What? _____
 Smoke currently? _____ If yes, packs per day _____
 How did you hear about our practice? _____

Patient Signature: _____ **Date:** _____

Reviewed By: _____ **MD Date:** _____