

Orthopedic Associates of Southwestern Ohio, Inc.

Patient History Form

NAME: _____

TODAY'S DATE: _____

SS#: _____

DATE OF BIRTH: _____

Why are you seeing the doctor today? _____

Current problem is the result of (check all that apply):

Work Accident: _____ Car Accident: _____ Accident: _____ Other: _____

This occurred during (check all that apply):

Lifting: _____ Reaching: _____ Pulling: _____ Squatting: _____ Pushing: _____

Hit by object: _____ Twisting: _____ Falling: _____ Bending: _____ Not known: _____

MEDICATION	DOSAGE	HOW LONG?	SIDE EFFECTS

ALLERGIES

REVIEW OF SYSTEMS

Are you currently having or have you had problems with your:

	CIRCLE		DESCRIBE ALL YES RESPONSES
Eyes	NO	YES	_____
Ears, Nose, Throat	NO	YES	_____
Lungs, Breathing	NO	YES	_____
Digestion	NO	YES	_____
Bowel movement	NO	YES	_____
Bladder problem	NO	YES	_____
Diabetes	NO	YES	_____
High blood pressure	NO	YES	_____
Bleeding problems	NO	YES	_____
Balance problems	NO	YES	_____
Numbness/Tingling	NO	YES	_____
Blackout/Fainting	NO	YES	_____
Psychological problems	NO	YES	_____
AIDS	NO	YES	_____
Cancer	NO	YES	_____
Arthritis	NO	YES	_____
Polio	NO	YES	_____
Tuberculosis (TB)	NO	YES	_____
Epilepsy	NO	YES	_____

Reviewed by: _____, D.O. Date: _____