THIS IS AN INFORMATIONAL FORM AND IS NOT A PERMANENT PART OF THE MEDICAL RECORD

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WATSON CLINIC LLP
Quality Healthcare for Every Generation

Orthopaedics & Sports Medicine

MEDICAL HISTORY

BP: __________/__________
P: __________ T:_________
Ht: ____________________
Wt: ____________________

Date: ________________________________

Name: ____ Age: __________ Sex: ☐ M ☐ F Race: ______________________
PLEASE PRINT

Health History of Patient	Yes	No
Stroke	☐	☐
Heart Trouble	☐	☐
High Blood Pressure	☐	☐
Diabetes	☐	☐
Arthritis	☐	☐
Gout	☐	☐
Seizures	☐	☐
Mental Illness	☐	☐
Kidney Disease/Stones	☐	☐
Cancer	☐	☐
Bleeding Disorders	☐	☐
Alcoholism	☐	☐
Lung Disease	☐	☐
Blood Clots	☐	☐
Anemia	☐	☐
Stomach Ulcers	☐	☐
Liver Disease	☐	☐
Thyroid Problems	☐	☐
Previous Fracture	☐	☐

Explain YES Answers Below:

____
____
____

Prior Surgeries (w/Dates):

____
____
____

Current Medications/Dosage:

____
____
____

Allergies NONE ☐

____
____

Social History

Most Recent Occupation: ___________________
____

☐ Married ☐ Single
☐ Divorced ☐ Widowed

Number of Living Children___________________
Presently living alone? ____________________
Smoking History: __________________packs/day
Alcohol: ☐ Never ☐ Occasional ☐ Past Problem ☐ Frequently Use

Family History	Yes	No
Stroke	☐	☐
Heart Trouble	☐	☐
High Blood Pressure	☐	☐
Diabetes	☐	☐
Arthritis	☐	☐
Gout	☐	☐
Seizures	☐	☐
Mental Illness	☐	☐
Kidney Disease/Stones	☐	☐
Cancer	☐	☐
Bleeding Disorders	☐	☐
Alcoholism	☐	☐

Explain YES Answers Below:

____
____
____

Parents/Siblings Cause of Death:

____
____
____

Review of Systems	Yes	No
Reading Glasses	☐	☐
Vision Changes	☐	☐
Hearing Loss	☐	☐
Ear Pain	☐	☐
Hoarseness	☐	☐
Nosebleeds	☐	☐
Difficulty Swallowing	☐	☐
Morning Cough	☐	☐
Short of Breath	☐	☐
Fever/Chills	☐	☐
Heart/Chest Pain	☐	☐
Abnormal Heartbeat	☐	☐
Swollen Ankles	☐	☐
Calf Cramps w/Walking	☐	☐
Poor Appetite	☐	☐
Toothache	☐	☐
Stomach Pain	☐	☐
Gas	☐	☐
Nausea/Vomiting	☐	☐
Diarrhea	☐	☐
Bloody Bowel Movements	☐	☐
Constipation	☐	☐
Hemorrhoids	☐	☐
Frequent Urination	☐	☐
Poor Bowel Control	☐	☐
Poor Bladder Control	☐	☐
Headaches	☐	☐
Blackouts	☐	☐
Seizures	☐	☐
Hot/Cold Spells	☐	☐
Rashes	☐	☐
Recent Weight Change	☐	☐
Insomnia	☐	☐
Depression	☐	☐

WOMEN ONLY	Yes	No
Irregular Periods	☐	☐
Vaginal Discharge	☐	☐
Frequent Spotting	☐	☐

OTHER

Leisure Activities/Hobbies:

____
____
____
____

Athletic Activities:

____
____

Hand Dominance ☐ Right ☐ Left

PRESENT COMPLAINT:

Chief Complaint: ______________________
____
____

Since when?___________________________
____

Was there an injury?____________________
____
____

Where is your pain? ____________________
____
____

Describe your pain:
☐ Numb ☐ Pressure ☐ Sharp
☐ Dull ☐ Crampy ☐ Throbbing
☐ Locking ☐ Unstable
☐ Constant ☐ Intermittent

What makes symptoms . . .
Worse? ______________________________
____
Better? ______________________________
____

Previous Studies (X-ray, MRI, Blood Tests):

____
____

Prior Treatment:
☐ Steroid Injection
☐ Oral Medication
☐ Surgery
☐ Physical Therapy
☐ Other (describe): ____________________
____

Initials _______________