

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 | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Trouble | <input type="checkbox"/> | <input type="checkbox"/> |
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis | <input type="checkbox"/> | <input type="checkbox"/> |
| Gout | <input type="checkbox"/> | <input type="checkbox"/> |
| Seizures | <input type="checkbox"/> | <input type="checkbox"/> |
| Mental Illness | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney Disease/Stones | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> |
| Bleeding Disorders | <input type="checkbox"/> | <input type="checkbox"/> |
| Alcoholism | <input type="checkbox"/> | <input type="checkbox"/> |
| Lung Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood Clots | <input type="checkbox"/> | <input type="checkbox"/> |
| Anemia | <input type="checkbox"/> | <input type="checkbox"/> |
| Stomach Ulcers | <input type="checkbox"/> | <input type="checkbox"/> |
| Liver Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Previous Fracture | <input type="checkbox"/> | <input type="checkbox"/> |

- Family History**
- | | Yes | No |
|-----------------------|--------------------------|--------------------------|
| Stroke | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Trouble | <input type="checkbox"/> | <input type="checkbox"/> |
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis | <input type="checkbox"/> | <input type="checkbox"/> |
| Gout | <input type="checkbox"/> | <input type="checkbox"/> |
| Seizures | <input type="checkbox"/> | <input type="checkbox"/> |
| Mental Illness | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney Disease/Stones | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> |
| Bleeding Disorders | <input type="checkbox"/> | <input type="checkbox"/> |
| Alcoholism | <input type="checkbox"/> | <input type="checkbox"/> |

- WOMEN ONLY**
- | | Yes | No |
|-------------------|--------------------------|--------------------------|
| Irregular Periods | <input type="checkbox"/> | <input type="checkbox"/> |
| Vaginal Discharge | <input type="checkbox"/> | <input type="checkbox"/> |
| Frequent Spotting | <input type="checkbox"/> | <input type="checkbox"/> |

OTHER
 Leisure Activities/Hobbies:

Explain YES Answers Below:

Explain YES Answers Below:

Athletic Activities:

 Hand Dominance Right Left

Prior Surgeries (w/Dates):

Parents/Siblings Cause of Death:

PRESENT COMPLAINT:
 Chief Complaint: _____

 Since when? _____

Current Medications/Dosage:

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

Was there an injury? _____

 Where is your pain? _____

Allergies NONE

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

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

What makes symptoms . . .
 Worse? _____

 Better? _____

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

Prior Treatment:
 Steroid Injection
 Oral Medication
 Surgery
 Physical Therapy
 Other (describe): _____
