

HISTORY OF PRESENT ILLNESS

PLEASE ANSWER ALL QUESTIONS

1. For what problem / condition are you seeing Dr. Goldhagen today?
2. When did your orthopedic problem first appear?
3. Is your orthopedic problem the result of an injury? Yes / No Explain
4. Is your orthopedic problem work related? Yes / No Explain
5. Have you ever had this or a similar problem before? Yes / No Explain
6. Have you been seen elsewhere for THIS problem? Yes / No

Emergency Room	Yes / No	When?
Family Physician	Yes / No	When?
Orthopedic Surgeon	Yes / No	When?

What was the diagnosis?

7. Have you had an x-rays, MRI, CT scan, or bone scan for THIS problem?
Yes / No Where?
8. Have you had any treatment for THIS problem? Yes / No

Medication	Yes / No	List
Physical Therapy	Yes / No	
Surgery	Yes / No	Describe (on reverse)

9. Who is your primary care physician?
10. How were you referred to Dr. Goldhagen?

11. Height _____ Weight _____

Date: _____

**PAST MEDICAL HISTORY: Please circle all that apply–
IF NONE APPLY, CIRCLE NONE**

Arthritis: Gout / Lupus / Osteoarthritis / Rheumatoid arthritis / None
Bleeding: Hemophilia / Sickle Cell Anemia / Anemia / None
Cancer: Where? / None
Cardiac: Arrhythmias/Heart attack / High Blood Pressure / Heart Failure / None
Diabetes: Yes / No If yes, Insulin / Oral Medication / Diet Controlled
Endocrine: Hypothyroidism / Hyperthyroidism / None
G. I. Esophagitis/Gall stones/Gastritis/Hepatitis/Hiatal Hernia/Ulcers/None
G. U. Urinary tract infections / Kidney stones / None
Muscular: Sprains / Strains / Tears / Ligament or tendon injury / None
Psychiatric: Depression/Anxiety /Paranoia/Schizophrenia /Manic depression/None
Pulmonary: Asthma / Bronchitis / Emphysema / Pneumonia / TB / None
Skeletal: Broken (fractured) Bone / Osteoporosis / None
Vascular: Blood Clot / Stroke / Varicose Veins / Poor Circulation / None
Other: _____

FAMILY MEDICAL HISTORY: List any of the above in the following relatives:

Father:

Mother:

Sibling:

Child:

PAST SURGICAL HISTORY:

Type of Surgery	Hospital / Date	Complications
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICATIONS: (Include non-prescription): Name and dosage, or circle NONE

Do you currently take Coumadin/Plavix /Aspirin/Other Blood Thinner(please circle)

Have you ever received a blood product transfusion? Yes / No When?

PAST MEDICAL HISTORY

ALLERGIES: List and describe your allergic reaction to any medication, or circle NONE

Do you have a latex allergy? Yes / No

SOCIAL HISTORY: Please circle

Marital status: Single / Married / Divorced / Widowed

Living Conditions: Alone / Significant Other / Spouse / Family

Housing Condition: House / Apartment / Mobile Home / Assisted Living / Nursing Home

Tobacco: Yes / No If yes, how much? 1 / 2 / 3 / 4 packs per day

Alcohol: Yes / No Beer / Wine / Liquor Never / Social / Heavy

Recreational (street) drugs: Yes / No Which ones?

Occupation:

Recreational / Sports activities: Describe, or state none

REVIEW OF SYSTEMS: Please circle if you now have, or have recently been experiencing any of the following:

Cardiac

Chest pain

Palpitations

Shortness of breath

Vision

Double vision

Blurred vision

Vision loss

Hematologic

Abnormal bleeding

Abnormal bruising

Neurological

Dizziness

Seizures

Constitutional

Fevers

Chills

Night sweats

Recent weight loss

Swollen glands

Gastrointestinal

Abdominal pain

Heart burn

Food intolerance

Diarrhea

Constipation

Skin

Skin rash

Hair loss

Severe itching

Psychiatric

Difficulty sleeping

Anxiety

Depression

Ear/Nose/Throat

Ringing in ears

Nose bleeds

Sore throat

Genitourinary

Difficulty urinating

Urinary frequency

Painful urination

Musculoskeletal

Joint pain

Joint stiffness

Muscular pain

Date: _____

