TAMPA ORTHOPAEDIC & SPORTS MEDICINE

Name:________________ Birthdate:________________ Date:________________
Sex:________ Race:________________
Height________________
Weight________________

Health History of the Patient

	Yes	No
Stroke		
Heart Trouble		
High Blood Pressure		
Diabetes		
Arthritis Type________		
Gout		
Seizures		
Mental Illness		
Kidney Trouble/Stones		
Cancer Type________		
Bleeding disorders		
Alcoholism		
Serious injuries		
Lung disease		
Tuberculosis		
Phlebitis		
Anemia		
Stomach ulcers		
Liver trouble		
Thyroid trouble		
HIV		
Hepatitis		
Osteoporosis		
Other Illnesses		

Explain all Yes answers:
____
____
____

List all Surgeries (include approx. dates)
____
____
____
____

Allergies to Medicine (None)
____
____
____
____

Family History

	Yes	No
Stroke		
Heart trouble		
High blood pressure		
Diabetes		
Arthritis		
Gout		
Seizures		
Mental Illness		
Kidney trouble/stones		
Cancer		
Bleeding disorders		
Alcoholism		
Other		

Explain all Yes answers:
____
____
____

Cause of death parents, brother or sisters
____
____
____
____

Current Medications/Vitamins/Supplements and dosage:
____
____
____
____
____
____
____

Review of Systems

Do you currently have?

	Yes	No
Reading glasses		
Change of vision		
Loss of hearing		
Shortness of breath		
Chills or fever		
Heart of chest pain		
Abnormal heartbeat		
Badly swollen ankles		
Calf cramps with walking		
Poor appetite		
Nausea or vomiting		
Stomach pain		
Ulcers		
Bowel incontinence		
Frequent urination		
Burning on urination		
Difficulty starting urination		
Difficulty stopping urination		
Recent weight change		
Are you pregnant?		
Are you nursing?		

Social History

Most recent occupation/grade in school
____
____

☐ Married ☐ Single
☐ Divorced ☐ Widowed

Number of children ________________
Presently living alone? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No
Smoke_____ packs per day

Alcohol: ☐ Never ☐ Occasional
☐ Moderate to Heavy

Do you use illegal drugs ☐ Yes ☐ No

Patient Signature
____

MD Initials ________________