

Rockingham Orthopaedic Associates

Patient – Present Injury/Illness Form

Name: _____ Date: _____

Date of Birth: _____ Age: _____

Chief Complaint (Why are you seeing the doctor today?) _____

Is this problem on the: Right _____ Left _____ Date of Injury: _____

Describe Injury/Present Illness in Detail. _____

Referring Physician Name: _____ Phone #: _____

Primary Care Physician Name: _____ Phone #: _____

Pharmacy Name: _____ City _____ State _____

Past Medical History

Medical Condition	No	Yes	Medical Condition	No	Yes
Arthritis			Infections		
Blood Transfusion(Year?) _____			Kidney Disease		
Cancer			Liver Disease		
Diabetes			Neurological Disorder		
Epilepsy/Seizure disorder			Psychiatric Problem		
GI Disease (ulcers)			Respiratory Disease/lung disease		
Heart Disease			Stroke		
Hepatitis			Thyroid Disease		
Hypertension (high blood pressure)			Vascular Disease/Circulatory problems		
HIV or other immune deficiency					
Other Orthopedic problems:					

Surgeries/Hospitalizations	Year

Please list all medications you are currently taking, including herbal supplements and vitamins.

MEDICATION	Dose	MEDICATION	Dose

ALLERGIES: (adhesive tape, drugs, dyes, food, injectable medication, iodine, latex, metal, shellfish, steroids, etc.)

Patient (or guardian) Signature: _____ **Date:** _____

Reviewed By: _____, MD **Date:** _____

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PATIENT HEALTH HISTORY FORM

Name: _____
 Height _____ Weight _____

Family History

Please list Family History of above diseases (ie: diabetes, heart disease, neuromuscular, etc)

Mother:
Father:
Grandparents:

Social History

Work in the home: Y _____ N _____ Employed (occupation _____)

Student: Y _____ N _____ Grade _____ Retired _____

Single _____ Married _____ Divorced _____ Separated _____ Widowed _____

Children? No _____ Yes # _____

Do you live alone? No _____ Yes _____

Exercise? Daily _____ Weekly _____ Monthly _____ Rarely _____

What type of exercise? _____

Recreational Activities? _____

Drink Alcohol? Never _____ Daily _____ 1-2X/Week _____ 1-2X/Month _____ 1-2X/Year _____

Smoke currently? No _____ Yes _____ If yes, # of packs per day? _____

Review of Symptoms

Are you currently having or have you had problems with:

Symptom	No	Yes	Symptom	No	Yes
Blackout/Dizziness			Fever/Chills/Sweats/Fatigue		
Bladder/Bowel movement			Headache		
Bleeding Problems			Lower Back pain		
Changes in skin color/texture			Lungs, Breathing/Cough		
Chest pain/Palpitation			Muscle/Bone/Joint pain		
Digestion			Numbness/Tingling		
Ears, Nose, Throat			Swelling/Discoloration – Extremity		
Eyes/Visual disturbance			Weight loss or gain		
Other:					

Patient (or guardian) Signature: _____ **Date:** _____
Reviewed By: _____, MD **Date:** _____