



General History Form

Name: _____ Age: _____ Today's Date: _____

WHO REFERRED YOU: FAMILY/ FRIEND HOSPITAL DOCTOR _____

Family physician/ Primary care physician: _____ Phone #/Fax # _____

WHY ARE YOU SEEING THE DOCTOR TODAY? _____

Date of Injury: _____ Place Injury occurred at: _____ Side: Right Left Bilateral

Cause of injury: _____

CURRENT MEDICATIONS	DOSE	HOW LONG	REASON FOR USE

PAST SURGERY(IES)	DATE	SURGEON

DO YOU HAVE ANY PROBLEMS WITH THE FOLLOWING?

- Lungs / Breathing No Yes, explain: _____
- Diabetes No Yes, explain: _____
- High Blood Pressure No Yes, explain: _____
- Bleeding Problems No Yes, explain: _____
- Balance Problems No Yes, explain: _____
- Numbness/Tingling No Yes, explain: _____
- History Of Cancer No Yes, explain: _____
- Psychological No Yes, explain: _____
- Other No Yes, explain: _____

Allergies: _____

Height _____ Weight _____

Social History (circle one of the following): Retired Not employed Full time student Disabled Employed

Occupation: _____

Do You Smoke? No Yes How Much _____ How Long _____

Do You Drink Alcohol? No Yes How Often _____

Do You Live Alone? No Yes, with whom _____

I acknowledge and understand that, in presenting myself for treatment and continuing medical care at Southwest Orthopedic, S.C. that I authorize and consent to the administration and performance of all tests and treatments which may be ordered by the physician (and/or designated assistant) and carried out by members of Southwest Orthopedics, S.C. medical staff and personnel. Minors must be accompanied by a parent/legal guardian for medical care except when the minor is seeking specific services for which they are not required to obtain parental consent, accompaniment or guidance, as clearly expressed by state law.

Patient/Parent/Legal Guardian/Relative

Date