

Northside Atlanta Orthopedics & Sports Medicine

Name: _____ DOB: _____ Height: _____ Weight: _____

Referred by: _____ Primary Care Physician: _____

Have you seen another physician regarding this condition? Yes / No If yes, list names and dates: _____

PAST MEDICAL HISTORY

• Neurological

Stroke	YES	NO
Concussion	YES	NO
Peripheral Neuropathy	YES	NO
Epilepsy/Seizures	YES	NO

• Cardiovascular

Heart Attack	YES	NO
High Blood Pressure	YES	NO
Coronary Artery Disease	YES	NO
Elevated Cholesterol	YES	NO
A-Fib/Irregular Heartbeat	YES	NO
Pacemaker	YES	NO

• Kidney

Renal Insufficiency	YES	NO
Kidney Stones	YES	NO
One Kidney/Abnormal Kidney	YES	NO

• Gastrointestinal

Ulcers	YES	NO
Reflux	YES	NO
Intolerance to NSAIDS	YES	NO

• Skin

Psoriasis	YES	NO
History of skin rash	YES	NO

• Endocrine

Diabetes	YES	NO
Thyroid Disease	YES	NO
Prednisone Use	YES	NO

• Pulmonary

Asthma	YES	NO
Emphysema	YES	NO
COPD	YES	NO
Pulmonary Embolism	YES	NO

• Infectious

HIV/AIDS	YES	NO
Hepatitis B	YES	NO
Hepatitis C	YES	NO
TB	YES	NO
Recent Tick Bite	YES	NO
MRSA	YES	NO

• Cancer

Type:	YES	NO
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• Musculoskeletal

Osteoarthritis	YES	NO
Rheumatoid Arthritis	YES	NO
Fibromyalgia	YES	NO
Osteoporosis	YES	NO
Gout	YES	NO

• Hematological

Bleeding Problems	YES	NO
Blood Clots	YES	NO
Anemia	YES	NO
Blood Transfusion	YES	NO

If you answered yes to any question, please explain:

Problem Not Listed

Explain:	YES	NO
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REVIEW OF SYSTEMS Are you experiencing any of the following?

• Neurological

Dizziness	YES	NO
Vertigo	YES	NO
Fainting	YES	NO
Motor disturbances	YES	NO
Sensory disturbance	YES	NO

• Cardiovascular

Chest pain or discomfort	YES	NO
Fast heart rate	YES	NO
Palpitations	YES	NO

• Otolaryngeal

Earache	YES	NO
Hearing loss	YES	NO
Ringing in Ears	YES	NO
Nosebleeds	YES	NO
Nasal discharge	YES	NO
Mouth Sores	YES	NO
Bleeding gums	YES	NO
Hoarseness	YES	NO
Throat Pain	YES	NO

• Pulmonary

Coughing up blood	YES	NO
Cough	YES	NO
Wheezing	YES	NO
Difficulty breathing	YES	NO

• Constitutional

Recent change in weight	YES	NO
Chills	YES	NO
Fever	YES	NO
Sweating heavily at night	YES	NO

• Gastrointestinal

Difficulty swallowing	YES	NO
Heartburn	YES	NO
Nausea	YES	NO
Vomiting	YES	NO
Abdominal pain	YES	NO
Diarrhea	YES	NO
Black or tarry stool	YES	NO

• Hematologic

Easy bleeding	YES	NO
Easy bruising	YES	NO

• Genitourinary

Blood in Urine	YES	NO
Bowel/bladder changes	YES	NO
Bladder pain	YES	NO

• Musculoskeletal

Joint stiffness	YES	NO
Muscle aches	YES	NO
Joint pain	YES	NO

• Skin

Itching	YES	NO
Skin lesion	YES	NO
Skin rash	YES	NO

• Claustrophobic

	YES	NO
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PAST MEDICAL HISTORY

ALLERGIES:

I have no allergies to medications I have no allergies to foods Allergic to metal Yes No

Allergic to:	Reactions:

CURRENT MEDICATIONS: (include dosage)

PAST SURGICAL PROCEDURES: (please list all and year)

FAMILY HISTORY: (parents, siblings and grandparents)

- Unknown family medical history Diabetes Heart Disease Bleeding problems Lung disease
 Blood clots Stroke Cancer Kidney disease
 Hip/spine fracture High Blood Pressure Osteoporosis Sickle Cell Anemia

SOCIAL HISTORY:

What is your current occupation _____

Are you currently pregnant or nursing? Yes No

Do you currently use tobacco products? Yes _____ ppd No

Quit smoking? Yes No

Do you drink alcohol? Never Daily 1-2 week 1-2 month 1-2 year

Do you currently use or have a history of illicit substance abuse? Yes No

EMOTIONAL/SPIRITUAL/CULTURAL NEEDS:

Mental/Emotional: Anxiety Depression Job Loss Divorce Death of Someone Close to you New Job

Under Care of Psychiatrist/Psychologist Name: _____ Live alone? Y / N

Do you have concerns about your safety, the safety of anyone in your home or security of your property? Y / N

Patient signature: _____ Date/Time: _____

Physician's signature: _____ Date/Time: _____