THE ORTHOPEDIC CENTER OF ST. LOUIS

NEW PATIENT HEALTH HISTORY

Dr. Chris Reeves

Date of Visit _____

Name _____ DOB _____ Gender ☐ M ☐ F

Who referred you to Dr. Reeves? _____ Phone Number _____

Patient Phone Number: _____ Height _____ Weight _____

Hand Preference ☐ Right ☐ Left Are you pregnant? ☐ No ☐ Yes ☐ Unknown

Primary Care Provider _____ Phone _____

Preferred Pharmacy _____ Phone _____

Work Compensation Information Claim Number: _____ Date of Injury: _____

Employer: _____

Claims Adjuster: _____ Phone Number: _____ Fax: _____

Case Manager: _____ Phone Number: _____ Fax: _____

CHIEF COMPLAINT

Please describe your current injury/complaint. _____

How long have you experienced this condition? _____

What makes your symptoms better (ie, rest, medication)? _____

What makes your symptoms worse (ie, walking, bending)? _____

Which of your symptoms caused you the most concern? _____

Date of onset/injury _____ Were you in an auto accident? _____

Is this a work-related injury? ☐ YES ☐ NO Who is your case manager/case adjuster? _____

Have you had any x-rays or test performed for this condition?

☐ **YES (PLEASE BRING IMAGES ON DISC)** ☐ **NO**

Type of test/scan _____

Date _____ Where was it done? _____

Type of test/scan _____

Date _____ Where was it done? _____

Type of test/scan _____

Date _____ Where was it done? _____

Have you had any prior treatment for this condition? ☐ **YES** ☐ **NO**

Describe _____

PAST MEDICAL HISTORY: *Please check if you have now, or have had in the past, any of these medical conditions.*

☐ **NO PAST MEDICAL PROBLEMS**	☐ Arrhythmia	☐ Asthma
☐ Heart Attack	☐ Anemia	☐ Pneumonia
☐ Angina or Chest Pain	☐ Bleeding Ulcer	☐ Chronic Bronchitis
☐ Congestive Heart Failure/Heart Disease	☐ Headache/Migraines	☐ Blood Clot in Lung
☐ Mitral Valve Prolapse	☐ Sleep Apnea	☐ Tuberculosis
☐ High Blood Pressure	☐ Lung Disease	☐ Liver Problems
☐ High Cholesterol/Triglycerides	☐ Emphysema (COPD)	☐ Diabetes- ☐ Insulin ☐ Non-Insulin

☐ Psychiatric history	☐ Diverticulitis	☐ Thyroid Problems
☐ Anxiety	☐ Osteoarthritis	☐ Kidney Stones / Disease
☐ Depression	☐ Ulcerative Colitis	☐ Urologic Problems
☐ Schizophrenia	☐ Hiatal Hernia	☐ Stress Incontinence
☐ Blood Clot/DVT	☐ Reflux	☐ Enlarged Prostate
☐ Legs ☐ Lungs ☐ Other	☐ Stomach or Intestinal Ulcer	☐ Frequent Urinary Inf (UTI)
☐ Peripheral Vascular Disease	☐ Crohn's Disease	☐ Problems with Anesthesia
☐ Peripheral Neuropathy	☐ Irritable Bowel	☐ Seizure Disorder
☐ Cancer _____	☐ Peptic Ulcer Disease	☐ Other _____
☐ Fracture(s) _____	☐ Crohn's Disease	☐ Other _____
☐ Hepatitis __	☐ Intestinal Bleeding	☐ Other _____
☐ HiV+	☐ Fibromyalgia	☐ Comments _____

SURGICAL HISTORY: *Please check if you have had any of these surgeries.*

☐ **NO PREVIOUS SURGERY**	☐ Breast Surgery	☐ Prostate Surgery
☐ Abdominal Surgery	☐ Type _____	☐ Other (explain)
Type: _____	☐ Carotid Surgery	_____
☐ Aneurysm	☐ Colon Surgery	_____
☐ Angioplasty/Stents	☐ Coronary Bypass (CABG)	_____
☐ Artery Bypass of Arm or Leg	☐ Heart Valve Replacement	_____
☐ Bone/Joint Surgery	☐ Hysterectomy	_____
Type _____	☐ Pacemaker/Defibrillator	_____

☐ Back/Neck Surgery

☐ Cervical (neck)	Level(s) _____	When?	
☐ Thoracic	Level(s) _____	When?	_____
☐ Lumbar (low back)	Level(s) _____	When?	_____

☐ Implanted Devices *(If YES, check all that apply.)*

☐ Spinal Cord Stimulator	☐ Pacemaker	☐ IUD	☐ Venous Access
☐ Aneurysm Clip(s)	☐ AICD	☐ Breast Implant	☐ Screws, Pins, Plates
☐ Intrathecal Pump	☐ Insulin Pump		Where? _____

MEDICATION ALLERGIES (PLEASE REVIEW/FILL OUT ATTACHED MEDICATION LIST)

☐ **NO KNOWN MEDICATION ALLERGIES**			
Are you allergic to Contrast Dye?	☐ NO	☐ YES	Reaction:
Are you allergic to Latex?	☐ NO	☐ YES	Reaction:
Are you allergic to Tape?	☐ NO	☐ YES	Type of tape or adhesive / reaction:
Are you allergic to any Food Items?	☐ NO	☐ YES	Type of food / reaction:
Medication Allergy:			Reaction:
Medication Allergy:			Reaction:
Medication Allergy:			Reaction:
Medication Allergy:			Reaction:
Medication Allergy:			Reaction:

FAMILY HISTORY:

*Please check below if any immediate relatives have had any of these conditions: **F**–father, **M**–mother, **S**-sibling.*

☐ Adopted

☐	**NO FAMILY HISTORY TO REPORT**	☐	Cancer	☐	Stroke
☐	Heart Disease	☐	Liver Disease	☐	Diabetes
☐	Lung Disease	☐	Arthritis	☐	Psychiatric Disease
☐	Osteoporosis	☐	High Blood Pressure	☐	Other (Explain)
☐	Anesthesia Difficulties	☐	Kidney Disease		_____
☐	Bleeding Disorders	☐	Rheumatoid Arthritis		_____
☐	Other Inherited Disease (type)				

Patient Name _____ DOB _____ Date of Visit _____

SOCIAL HISTORY:

Occupation									
Work Demands	☐	Sedentary	☐	Moderately Active	☐	Heavy Labor			
Work Status	☐	Working	☐	Retired	☐	Disabled	☐	Other	
Education Level	☐	Grade School	☐	High School	☐	Technical School	☐	Associated Degree	
	☐	Bachelor's Degree	☐	Master's Degree	☐	Doctorate			
Marital Status	☐	Single	☐	Married	☐	Partner	☐	Divorced	☐ Widow/Widower
Smoking	☐	Never Smoked			☐	Former Smoker	☐	Quit Date: _____	
Are you a current smoker?	☐	No	☐	Yes How many packs per day? _____					
Do you dip or chew tobacco?	☐	No	☐	Yes How much per day? _____					
Do you drink alcoholic beverages?	☐	No	☐	Yes How many drinks per week? _____					
Do you use recreational drugs?	☐	No	☐	Yes What and how often? _____					
Have you injected illegal drugs?	☐	No	☐	Yes What and how often? _____					
Do exercise regularly?	☐	No	☐	Yes Describe _____					
What sports/activities do you participate in?									

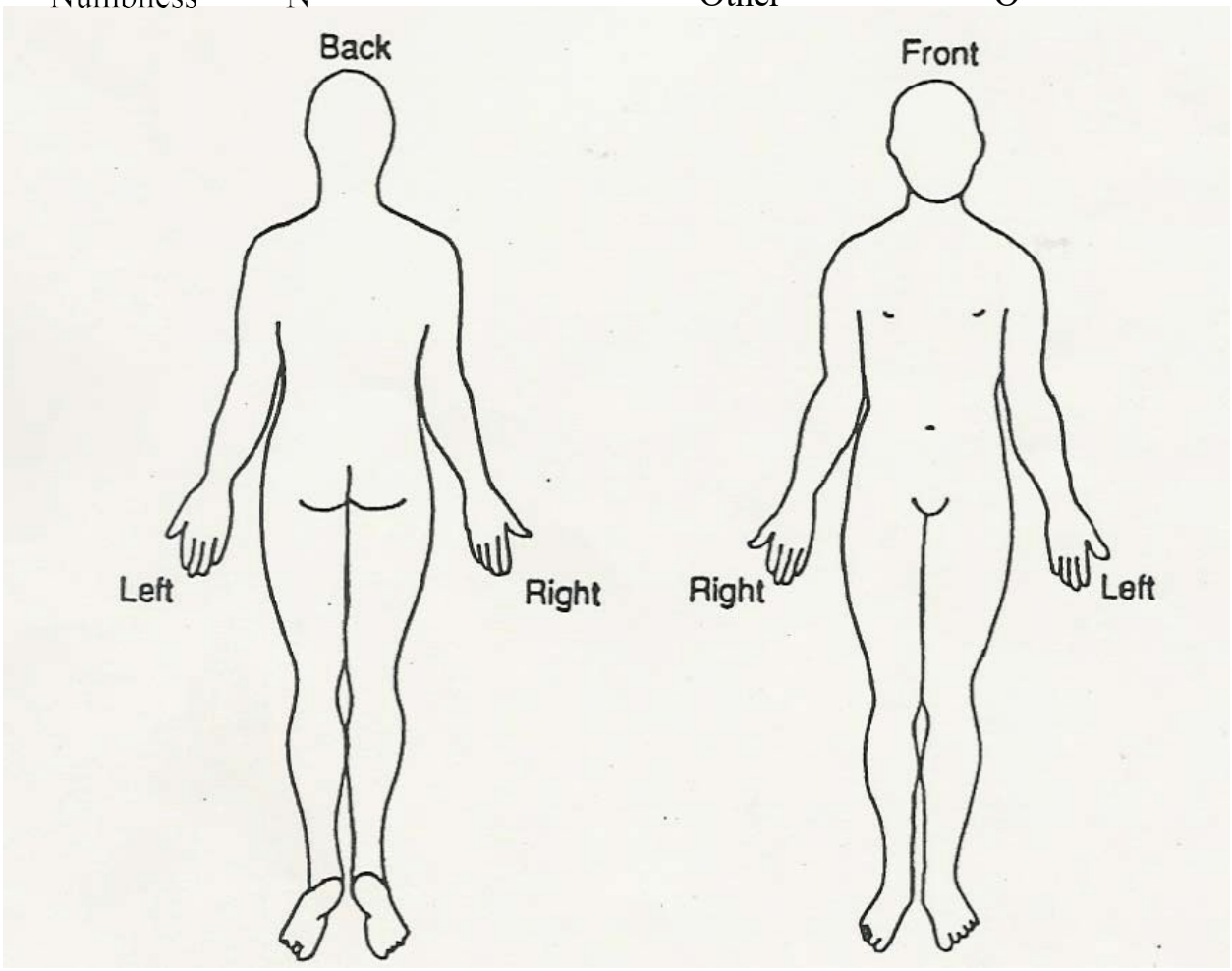
REVIEW OF SYSTEMS: *Please check if you have now, or recently experienced any of these medical conditions.*

☐	**Good General Health**	☐	Wheezing	☐	Dry Skin / Itching
☐	Recent Weight Gain / Loss	☐	Spitting up Blood	☐	Chronic Skin Ulcers
☐	Fever/Chills/Night Sweats	☐	Change in Bowel Habits	☐	Varicose Veins
☐	Fatigue	☐	Loss of Appetite	☐	Numbness / Tingling
☐	Eye Disease/Injury	☐	Nausea / Vomiting	☐	Blackouts
☐	Wear Glasses / Contacts	☐	Diarrhea	☐	Tremors
☐	Blurred / Double Vision	☐	Constipation	☐	Paralysis
☐	Hearing Loss / Ringing	☐	Indigestion	☐	Depression
☐	Chronic Sinus Problem	☐	Burning / Painful Urination	☐	Memory Loss or Confusion
☐	Nosebleed	☐	Frequent Urination	☐	Nervousness
☐	Difficulty Swallowing	☐	Blood in Urine	☐	Insomnia
☐	Shortness of Breath	☐	Joint Pain	☐	Slow Healing after Cuts
☐	Chest Pain	☐	Back Pain	☐	Bruising Tendency
☐	Palpitations	☐	Difficulty Walking	☐	Transfusions
☐	Faintness	☐	Muscle Weakness	☐	Excessive Thirst
☐	Breathing Problems	☐	Leg Cramps	☐	Excessive Sweating
☐	Chronic / Frequent Coughs	☐	Rashes	☐	Other _____

PAIN DIAGRAM

Please use the symbols below to show the area, upon the body outlines, in which you are experiencing pain.

Ache-	A	Pins and Needles	P
Burning-	B	Stabbing	S
Numbness-	N	Other-	O



The line below represents the intensity of the pain you are experiencing. Please make an "X" at the position on the scale which indicates how much pain you are feeling ***at this time***.

Date _____

1 **10**

NO PAIN **WORST PAIN IMAGINABLE**

Patient Medication List

Please list ALL medications (including prescription, over the counter, vitamins, dietary or nutritional supplements) which you may be taking routinely and/or on an as needed basis.

MEDICATION	DOSAGE	FREQUENCY	HOW TAKEN

I understand the need to inform Dr. Reeves of any changes in my medical condition. To the best of my knowledge, the information provided on this form is correct and accurate.

Signature of Patient / Legal Guardian

Date