Date___________________

Hospital for Special Surgery

Confidential Medical History

Name ____________________________________ Age _______ Birthdate_______________________

Home # __________________________________ Work # ____________________________________

Occupation_______________________________ Referred by _________________________________

○ Right Handed ○ Left Handed

Chief Complaint ____

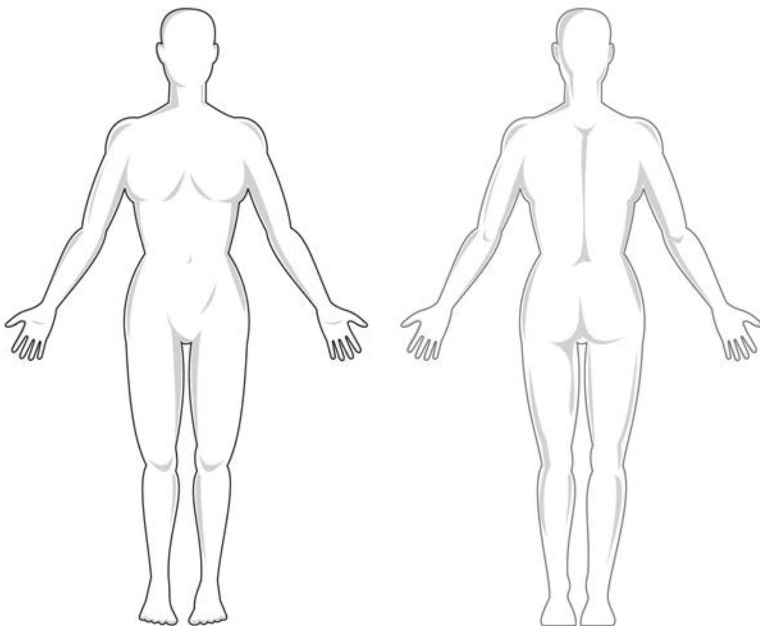
Date of injury or onset of symptoms ____

Describe the injury or problem____

____

____

Where is your pain? Please mark the drawing.



Rate Your Pain:

0 = No pain *10 = Extreme pain*

	0	1	2	3	4	5	6	7	8	9	10
1. Right now	○	○	○	○	○	○	○	○	○	○	○
2. At best	○	○	○	○	○	○	○	○	○	○	○
3. At worst	○	○	○	○	○	○	○	○	○	○	○

4. What makes it better?_______________

____

5. What makes it worse? _______________

____

Have you had any of the following tests or treatments for this problem? (please check)

Tests	**Date(s) of your tests**	**Treatments** (If so, describe whether they helped.)	
☐ X-RAY	___________________	☐ MEDICATIONS	______________________________
☐ MRI	___________________	☐ INJECTIONS	______________________________
☐ CT SCAN	___________________	☐ SURGERY	______________________________
☐ MYELOGRAM	___________________	☐ PHYSICAL THERAPY	______________________________
☐ BONE SCAN	___________________	☐ OTHER TESTS AND TREATMENTS	______________________________

Your Medical History

Do you have any medical problems? (Diabetes, high blood pressure, etc) ______________________

____

Have you ever been hospitalized? ○ Y ○ N If yes, why? ______________________

Have you ever had surgery? ○ Y ○ N If yes, why and when? ______________________

List of medications ____

Are you allergic to any medication? ○ Y ○ N If yes, list: ______________________

Are you allergic to any contrast dyes? ○ Y ○ N

Are you allergic or sensitive to latex? ○ Y ○ N

Family History

Does anyone in your family have any of the following problems? (please check)

☐ Heart disease ☐ High blood pressure ☐ Anesthesia complications ☐ Osteoporosis

☐ Cancer ☐ Nerve problems ☐ Blood problems (anemia, abnormal bleeding) ☐ Hip fracture

☐ Stroke ☐ Diabetes ☐ Osteoarthritis ☐ Other: ______________________

Current Symptoms or Problems

Please check Yes or No for any of the following that apply to you:

Yes	No	
☐	☐	Recent weight change
☐	☐	Change in bowel habits (also blood in stools)
☐	☐	Fatigue/weakness
☐	☐	Blood disorder or blood transfusion
☐	☐	Fever, chills
☐	☐	Easy bleeding
☐	☐	Easy bruising
☐	☐	Skin rash/disease
☐	☐	Change in urinary habits (including pain, blood in urine, trouble stopping/starting your urine)
☐	☐	Kidney disease or kidney stones
☐	☐	Vision problems/eye disease
☐	☐	Eating disorder
☐	☐	Nose/throat problem
☐	☐	Hearing problems/ear disease
☐	☐	Stomach pain or heartburn

Yes	No	
☐	☐	Ulcers
☐	☐	Hepatitis or gallbladder disease
☐	☐	Frequent headaches
☐	☐	Fainting spells
☐	☐	Seizures
☐	☐	Problems with coordination
☐	☐	Depression
☐	☐	Thyroid problems
☐	☐	Change in appetite or thirst
☐	☐	Shortness of breath or wheezing
☐	☐	Frequent cough
☐	☐	Chest pain
☐	☐	Heart murmur
☐	☐	Irregular heart beat
☐	☐	Heart disease
☐	☐	Swollen legs or feet

Social History

Do you smoke cigarettes? ○ Y ○ N ____ packs/day For how long? ___ yrs

Have you smoked in the past? ○ Y ○ N ____ packs/day For how long? ___ yrs Quit date _______

Do you drink alcohol? ○ Y ○ N _____ drinks/wk

Number of Children: ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 or more

Marital Status: ○ Married ○ Single ○ Widowed ○ Divorced

Physical Activity

How would you describe your level of physical activity over the past six months?

☐ Inactive - just daily activity

☐ Light - some walking, gardening, occasional weekend recreational activity

☐ Moderate - regular (3x per week) moderate exercise and occasional weekend sports

☐ Vigorous - regular (3-5x per week) vigorous exercise and/or sports activity

☐ Intense - competitive vigorous sports training

Height _______feet/inches Weight ________ lb

Do you consider your current weight ideal? ○ Y ○ N If no, list your ideal weight ________

Do you have questions about healthy ways to control your weight? ○ Y ○ N

Would you like us to send copies of your notes to your primary care physician? ○ Y ○ N

Primary Care Physician ____

Mailing Address ____

Phone # __________________________ Fax # ______________________________

Are there any specific questions that you would like to discuss today?

1. ____
2. ____
3. ____

Signed by Patient: ____ ***Date:*** __________________

Office only: *Reviewed by:* ________________________________ *Date:*__________________