Baylor Scott & White Orthopaedic Trauma Associates - New Patient Health History

First Name & Middle Initial::	Last Name:	Today's Date:
DOB:	Reason for visit:	Date of Onset:
Work Related injury? Yes No	Treatment received:	
Primary Care Physician/ Referring Physician:	PCP/Referring Physician Phone #:	
Pharmacy:	Pharmacy Address:	Pharmacy Phone:

Height	
Weight	

Medications (Please list any medications, presciption, over the counter and vitamins)

Name of Medicine	*How much do you take?* *EXAMPLE: 500 mg 2 drops 25 mcg 1 tablet 60 mg*	How do you take it? Example: By mouth	How often do you take it? Example: 1 time a day	Why do you take it? Example: blood pressure

Allergies

What are you allergic to? Example: medicines, iodine, latex	What happens to you? Example: Rash, dizzy, nausea

Surgical History

Ankle Surgery	Yes	No	Hand Surgery	Yes	No	Shoulder Surgery	Yes	No
Back Surgery	Yes	No	Heart Surgery	Yes	No	Spinal Fusion	Yes	No
Carpal Tunnel Release	Yes	No	Hip Surgery	Yes	No	Spine Surgery	Yes	No
Elbow Surgery	Yes	No	Knee Arthroscopy	Yes	No	Wrist Surgery	Yes	No
Foot Surgery	Yes	No	Knee Surgery	Yes	No			
Other Surgical History	Yes	No						
If "Yes," please explain what and when:								

Medical History

Alcoholism	Yes	No	Fractures	Yes	No	Inflammatory Arthritis	Yes	No
Anesthetic Complications	Yes	No	Gout	Yes	No	Kidney disease	Yes	No
Arthritis	Yes	No	Heart Disease	Yes	No	Liver disease	Yes	No
Autoimmune Disease	Yes	No	Hep C	Yes	No	Lung Disease	Yes	No
Cancer	Yes	No	HIV/AIDS	Yes	No	Osteoporosis	Yes	No
Clotting Disorder	Yes	No	Hyperlipidemia	Yes	No	Smoking	Yes	No
Deep Vein Thrombosis	Yes	No	Hypertension	Yes	No	Stroke	Yes	No
Diabetes Mellitus	Yes	No	Infectious Disease	Yes	No	Thyroid Disease	Yes	No
If "Yes," please explain:								

Family History

	Anesthesia Problems	Arthritis	Cancer	Clotting Disorder	Diabetes Mellitus	Deep Vein Thrombosis	Gout	Heart Disease	Hyperlipidemia	Hypertension	Thyroid Disease	Lung Disease	Osteoporosis	Ovarian Cancer	Hepatitis	HIV	Liver disease	Autoimmune disease	Kidney disease	Stroke
Mother																				
Father																				
Maternal Grandmother																				
Maternal Grandfather																				
Paternal Grandmother																				
Paternal Grandfather																				
Other																				
Details:																				

Social History

Alcohol Use:	Yes No	If Yes: # of Drinks/Week	
Drug Use	Yes No	# of Uses/Week and types	
Tobacco Use	Yes No	Types: Snuff/Chew/ Smokeless Tobacco Use	# of Packs/Day
Years of tobacco use			
Occupation	Employer	Full-time/Part-time	
Marital Status		If you have children, # of children	

Review of Systems

☐ Weight loss/gain	☐ Night Sweats	☐ Fever
☐ Double vision	☐ Blind Spots	☐ Ringing in Ears
☐ Vertigo/Dizziness	☐ Shortness of Breath: ☐ Chest Pain ☐ At rest ☐ With Activity	☐ Abdominal Pain ☐ Incontinence (Loss of control of Bowel Movements) ☐ Incontinence (Loss of control of Urine) ☐ Sexual Problems
☐ Pressure Sores	☐ Rash	☐ Easy Bruising
☐ Bleeding Disorder	☐ Heat/Cold Intolerance	☐ Diabetes
☐ Anxiety/Depression ☐ Difficulty sleeping ☐ Falls	☐ Irritability ☐ Cognitive Problems ☐ Spasm of Muscles	☐ Lack of Concentration ☐ Difficulty Speaking ☐ Behavioral Problems
☐ Stress in personal life	☐ Any chance that you are pregnant?	
☐ Describe in detail any checked boxes above:		