LONGVIEW ORTHOPAEDIC CLINIC ASSOCIATION
Personalized Medicine. Quality Care.

# Patient History

409 NORTH SIXTH STREET • LONGVIEW, TEXAS 75601 • TELEPHONE 903-758-2746 • FAX 903-758-7127

**Patient Name:**______________________________ **Birthdate (MM/DD/YYYY):** ______/______/________

To help us meet all of your healthcare needs, please fill out this entire form in ink. Let us know if you need assistance. This is a confidential record of your medical history and will be kept in this office. It will not be released unless authorized by you in writing.

Today's Date:

Occupation:

Previous Occupation:

Marital Status: Single Married Divorced Widow Sep

Hobbies / Exercise / Recreation:

HABITS

| | | | |
|---|---|---|---|
| Tobacco: | Yes | No | Type, Amount, Length of Time |
| Quit? | Yes | No | When? |
| Alcohol: | Yes | No | Type, amount per day / week: |

Recreational Drugs:

DRUG ALLERGIES and type of reaction:

Do you have a latex allergy? Yes No

Primary Doctor: City:

Who referred you to us?

PAST MEDICAL HISTORY:

| | | | | | |
|---|---|---|---|---|---|
| | | | Hepatitis | Y | N |
| Hypertension | Y | N | Diabetes | Y | N |
| Heart / Disease | Y | N | Thyroid | Y | N |
| AIDS | Y | N | Sickle Cell | Y | N |
| Gout | Y | N | Cancer (list type) | | |
| Rheumatoid Arthritis | Y | N | Other: | | |

PAST SURGICAL HISTORY (give dates):

MEDICATIONS (Include Non-prescription Drugs) or attach list:

Reason for today's visit? (Present health concerns, symptoms, or problems. For example: "Sore left knee for six weeks after a fall"):

**REVIEW OF SYSTEMS: Have you ever had any of the following? (Circle all that apply.).**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **General Constitutional:** | Weight loss | Weight gain | Activity tolerance (Increased or Decreased) | | | | |
| **Skin/Breasts:** | Rashes | Dry skin | Hair loss | Hair growth | Tenderness | Lump | |
| **Eyes/Ears/Nose/ Mouth/Throat:** | Headaches | Dizziness | Vision disturbance | Nose bleeding or discharge | Gum bleeding | Cavities | Neck pain |
| **Cardiovascular:** | Chest pain or tightness | Palpitations | Shortness of breath with exertion | | Heart murmur | | |
| **Respiratory:** | Shortness of breath | Wheezing | Cough | Tuberculosis | Fever | Night sweats | |
| **Gastrointestinal:** | Changes in appetite | Abdominal pain | Nausea | Vomiting | Changes in bowel habit | | |
| **Genitourinary:** | Changes in Frequency | Bloody | Discharge | Infections | Painful period | | |
| **Musculoskeletal:** | Pain | Swelling | Muscle weakness | Joint Pain | Cramps | Loss of motion | |
| **Neurologic/Psychiatric:** | Seizures | Tremor | Difficulty with memory | | Anxiety | Depression | |
| **Allergic/Immunologic/ Lymphatic/Endocrine:** | Allergy to Shellfish | Anemia | Intolerance to (Cold or Heat) | | Bleeding tendency | | |

**FAMILY HISTORY Has blood relative had any of the following:**

| | | | | | | |
|---|---|---|---|---|---|---|
| Cancer | Y | N | High Blood Pressure | Y | N | Disability? Please explain reason. Y/N |
| Sickle Cell | Y | N | Rheumatoid Arthritis | Y | N | |
| Diabetes | Y | N | Bleeding Disorder | Y | N | |
| Heart Disease | Y | N | Osteoporosis | Y | N | |
| Brittle bone Disease | Y | N | Scoliosis | Y | N | |
| Inherited joint disorders | Y | N | Hip Dysplasia | Y | N | |
| Lupus | Y | N | Ehlers - Danlos Syndrome | Y | N | |

Patient Signature: ______________________

Physician Review: Date: _____/_____/________