Henry County Orthopaedic Surgery And Sports Medicine, Inc.

1015 Kelley Drive, Suite 200 • Paris, Tennessee 38242 • 731-644-2271

Date ____________________________________ Patient Number ___________________

Name ____ Age ___________

Who is your family doctor? ____

When was your last physical? ____

Are you right or left handed? ____

Occupation: ____

Is this a work related injury? ____

MEDICAL HISTORY

List any medications to which you are ALLERGIC: ____

____

List any operations you have had and the approximate date of the procedures:

____

____

List any past fractured/broken bones: ____

____

Have you had any of the following?

_______ Cancer	________ Sugar Diabetes	________ Back pain or problems
_______ Arthritis	________ T.B.	________ Asthma or Lung Disease
_______ High Blood Pressure	________ Kidney Disease	________ Liver Disease
_______ Heart Trouble	________ Ulcers	________ Other _________________

Do you smoke? ____________ How much? ___________ How long? ___________ Do you drink alcohol?_________

Is there a possibility of your being pregnant at this time? ____

What is the purpose of your visit today? ____ __________

____

When did this begin? ____

Did another doctor send you here? _________ Please give name ____

Please check any of the following symptoms that you have now.

GENERAL:
- ________ unexplained weight loss
- ________ fever
- ________ chills
- ________ night sweats
- ________ bleeding disorder
- ________ history of blood transfusions

HEENT:
- ________ headaches
- ________ dizziness
- ________ double vision
- ________ blurred vision
- ________ hearing loss

RESPIRATORY:
- ________ cough
- ________ wheezing

CARDIAC:
- ________ chest pain
- ________ irregular heart beat
- ________ shortness of breath

SKIN:
- ________ rash
- ________ hair loss

GI:
- ________ constipation
- ________ diarrhea
- ________ blood in stools
- ________ nausea, vomiting
- ________ liver problems in past
- ________ hepatitis
- ________ ulcers

GU:
- ________ blood in urine
- ________ pain with urination
- ________ prostate problems

NERVE:
- ________ anxiety
- ________ seizures
- ________ depression
- ________ difficulty sleeping
- ________ fainting

MUSCLE/JOINTS/BONES:
- ________ morning stiffness
- ________ joint swelling
- ________ joint pain
- ________ muscle tenderness
- ________ muscle weakness

PATIENT SIGNATURE: ______________________________ **DATE:** ________________

PROVIDER REVIEW

Date ________ Changes ______________________________ Signature ________________

Date ________ Changes ______________________________ Signature ________________

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Date ________ Changes ______________________________ Signature ________________

Date ________ Changes ______________________________ Signature ________________

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