

ST. CHARLES ORTHOPAEDIC SURGERY ASSOCIATES, INC.
PATIENT HISTORY SHEET

Date: _____ Name: _____ D.O.B.: _____

PERSONAL & SOCIAL HISTORY:

Occupation: _____ Marital Status: _____

Children: _____ Habits: Sleep _____ hours/night Tea/Coffee _____ cups/day

Tobacco: packs/day for _____ years Alcohol: _____ weekday _____ weekend

FAMILY HISTORY:

- | | | |
|---|---|---|
| <input type="checkbox"/> Birth Defects | <input type="checkbox"/> Seizures | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Kidney Failure/Malfunction | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Heart Attack or Bypass Surgery | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Anemia/Bleeding Disorder |

1. When (roughly what date) did your present pain start? _____

Are you still working? _____ Last day on job _____

2. How did your pain start? (*example: suddenly, gradually, lifting, etc.*) _____

3. How long have you had this pain? _____ years _____ months _____ weeks

How long have you had similar pain? _____ years _____ months _____ weeks

4. Do you have any medical conditions such as:

- | | |
|--|--|
| <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Mental Health |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Heart Failure/Attacks | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Lungs | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Bowel or Bladder Problems | <input type="checkbox"/> Circulation |
| <input type="checkbox"/> Other _____ | |

5. Previous Surgeries: _____

6. List Medications you are currently taking with dosage: _____

7. Do you take antacids: Yes No

8. Do you have allergies to medications? Yes No Please List _____

9. Who is your primary doctor? _____

10. Do you have any additional information that would be helpful in understanding your problem? _____