MultiCare Orthopedics & Sports Medicine

NAME: _____ DOB: _____ TODAY'S DATE: _____
Last First MI

HEIGHT: _____ ft. _____ inches WEIGHT: _____ lbs. Gender Identity: _____ Preferred Pronouns _____

If female, are you or could you be pregnant? ❑ YES ❑ NO

REASON FOR TODAY'S VISIT: _____

_____

DATE OF INJURY/ONSET OF PROBLEM: _____

IS THIS WORK RELATED? ❑ YES ❑ NO WORKERS COMP CASE FILED? ❑ YES ❑ NO ❑ N/A

IS THIS RELATED TO AN ACCIDENT? ❑ YES ❑ NO ❑ AUTO ❑ OTHER: _____

DO YOU HAVE LEGAL ACTION PENDING REGARDING THIS INJURY? ❑ YES ❑ NO

NAME OF ATTORNEY: _____

WHO IS YOUR PRIMARY CARE PHYSICIAN? _____

MEDICAL HISTORY: ❑ NO MEDICAL CONDITIONS UNDER TREATMENT

List all current **medical problems:** _____ **List all current medications:** ❑ NONE

_____ _____

_____ _____

List all **DRUG ALLERGIES:** ❑ **NONE KNOWN** ❑ LATEX ❑ IODINE ❑ PENICILLIN ❑ SULFA

_____

SURGICAL HISTORY: ❑ NO SURGERIES

SURGERY	YEAR	SURGERY	YEAR
_____		_____	
_____		_____	
_____		_____	

Have you ever had any problems with anesthesia? ❑ YES ❑ NO ❑ N/A Explain: _____

FAMILY HISTORY:

	None	Mother	Father	Siblings		None	Mother	Father	Siblings
Heart Disease	❑	❑	❑	❑	Cancer	❑	❑	❑	❑
Stroke	❑	❑	❑	❑	High Blood Pressure	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	Mental Illness	❑	❑	❑	❑
Seizures	❑	❑	❑	❑	Thyroid Disease	❑	❑	❑	❑
Kidney Disease	❑	❑	❑	❑	Bleeding Disorders	❑	❑	❑	❑
Osteoarthritis	❑	❑	❑	❑	Rheumatoid Arthritis	❑	❑	❑	❑
Blood Clots/DVT	❑	❑	❑	❑	Sickle Cell	❑	❑	❑	❑
Asthma	❑	❑	❑	❑	Other: _____	❑	❑	❑	❑

Give details to "other" and any positive responses: _____

Patient Identification - Always Attach Patient Label

Name:

MRN #:

CSN #:

Age / Sex and Gender:

HEALTH HISTORY FORM

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REVIEW OF SYSTEMS:

Are you currently having, or have you had, problems with:

	NO	YES		NO	YES		NO	YES
Allergies/Hay Fever	❑	❑	Glaucoma	❑	❑	Old Fracture	❑	❑
Anemia	❑	❑	Gout	❑	❑	Osteoarthritis	❑	❑
Balance	❑	❑	Heart Disease	❑	❑	Osteomyelitis	❑	❑
Birth Defects	❑	❑	Hepatitis	❑	❑	Osteoporosis	❑	❑
Black out/Fainting	❑	❑	High Blood Pressure	❑	❑	Polio	❑	❑
Bladder	❑	❑	High Cholesterol	❑	❑	Rheumatic Fever	❑	❑
Bleeding Problems	❑	❑	HIV/AIDS	❑	❑	Shingles	❑	❑
Blood Clots	❑	❑	Joint Swelling	❑	❑	Sickle Cell	❑	❑
Cancer	❑	❑	Kidneys	❑	❑	Stomach Ulcers	❑	❑
Chest Pain	❑	❑	Liver	❑	❑	Stroke	❑	❑
Depression	❑	❑	Lungs	❑	❑	Thyroid Disease	❑	❑
Diabetes	❑	❑	Mental Illness	❑	❑	Tuberculosis	❑	❑
Emphysema	❑	❑	Migraines	❑	❑	Wound Healing	❑	❑
Epilepsy/Seizures	❑	❑	Multiple Sclerosis	❑	❑			
Fibromyalgia	❑	❑	Neurologic Problems	❑	❑	Other: _____		
Gallstones	❑	❑	Numbness/Tingling	❑	❑			

DESCRIBE ALL YES RESPONSES: _____

_____

_____

SOCIAL HISTORY:

Smoker ❑ YES ❑ NO _____ packs per day for _____ years

Quit Smoking ❑ YES ❑ NO Year _____ Previously smoked _____packs per day for _____ years

Chew Tobacco ❑ YES ❑ NO _____ cans per day for _____ years

Drink Alcohol ❑ YES ❑ NO _____ drinks per week

History of substance abuse/recreational drugs? ❑ YES ❑ NO What kind? _____

Do you live alone? ❑ YES ❑ NO

Children? ❑ YES ❑ NO # _____

Exercise? ❑ Never ❑ Rarely ❑ Weekly ❑ Daily

What kind of exercise? _____

Occupation: _____

❑ Student ❑ Retired ❑ Homemaker ❑ Disabled ❑ Unemployed

PHARMACY INFORMATION:

Name: _____ Location: _____

Patient Signature: _____ **Date:** _____

Reviewed By: _____ **Date:** _____

Provider Signature: _____ **Date:** _____

Body Diagram

Instructions: On the body diagram below, please indicate where your pain is located at the present time. Please do not indicate areas of pain that are not related to your present injury or condition.