Jason C. Snibbe, MD
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SNIBBE
ORTHOPEDICS

HISTORY FORM - NEW PATIENT

PATIENT NAME:______________________________ **TODAY'S DATE**______________

Who referred you to this office? ______________ **Internist/Family MD**______________

CHIEF COMPLAINT

1) What is the main reason for your visit today? ______________________ Right / Left / Both

HISTORY OF PRESENT ILLNESS

Age_____ Height________ Weight_______ Right/Left Handed______ Occupation______________

1) What was the date your symptoms started/were injured?______________________

2) Explain Injury: ____

____

3) Was this a work related accident? ☐ Yes ☐ No
If yes, are you still working? ☐ Yes ☐ No
If yes, are you working: ☐ Full ☐ Light duty

4) Was this an auto accident? ☐ Yes ☐ No
If so, were you driving? ☐ Yes ☐ No
Did airbags inflate? ☐ Yes ☐ No

5) Recreational or athletic injury? ☐ Yes ☐ No

6) Accident in your home? ☐ Yes ☐ No

7) On a scale of 1 (least) to 10 (greatest), what level is your pain today? 1 2 3 4 5 6 7 8 9 10

8) Describe symptoms you are having (check all that apply):

☐Aching	☐ Gives way	☐ Sharp	☐ Stabbing	☐Wakes you up
☐Clicking	☐ Locking	☐ Snapping	☐ Throbbing	☐ Weakness
☐Dull	☐ Numbness	☐ Sore	☐ Tingling	☐

9) How long does problem last? ☐ Constant ☐ Comes and goes ☐ Other:______________

10) Does anything make it better? ☐ Yes ☐ No Explain:______________
(eg: ice, rest, standing, sitting, meds, etc)

11) Does anything make it worse? ☐ Yes ☐ No Explain:______________
(eg: standing, sitting, bending, lifting, etc)

12) Does it radiate anywhere? ☐ Yes ☐ No If so, where:______________

13) List any other doctors you have seen for this problem:

____

14) List any previous tests, procedures, treatments (injections, physical therapy, medications) for this problem:

Physical Therapy: _________# of visits per week x _________weeks/months

Injections: How many?___________Date of last injection_____/_____/______Type of injection______________

Medications you have tried:______________________________________

Chiropractic/Acupuncture:__________# of visits

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MEDICATIONS

Are you sensitive or allergic to any medications? ☐ Yes ☐ No

If yes, please mark all that apply: ☐ Penicillin ☐ Keflex ☐ Aspirin ☐ Codeine ☐ Tetracycline ☐ Erythromycin ☐ Valium ☐ Demerol ☐ Barbituates ☐ Epinephrine ☐ Iodine ☐ Latex ☐ Naproxen ☐ Other________________

Are you currently taking:

Any cortisone-type medication (e.g. Prednisone)? ☐ Yes ☐ No
Any blood thinning medication (e.g. Coumadin, Warfarin, ASA, Plavix, etc)? ☐ Yes ☐ No
Family member ever had major adverse reaction to anesthesia? ☐ Yes ☐ No

If yes, Explain____

Please list all the medications you are currently taking and the dosages:

____
____
____
____

PAST MEDICAL HISTORY

Serious Childhood Illnesses:____

Adult Illnesses: List and document hospital stays if any_______________________________
____

Surgeries: List date, procedure, surgeon, and hospital__________________________________
____

Major accidents/Injuries with dates:____
____

FAMILY HISTORY

Father: Age if alive______ Age/death and cause_______________________________________

Mother: Age if alive______ Age/death and cause_______________________________________

Siblings: Age/health status____

Children: Age/health status____

Family Disease: (Hypertension, Diabetes, Tuberculosis, Gout, Cancer, etc)____________________
____

SOCIAL HISTORY

Do you smoke? ☐ Yes ☐ No If yes, how much?______How long?______

If no, did you ever smoke? ☐ Yes ☐ No If yes, how much?______How long?______Year quit______

Do you drink alcohol? ☐ Yes ☐ No If yes, how much?______How often?___________________

Do you take any drugs? ☐ Yes ☐ No If yes, what drugs?___________________________________

How often?____

Have you been or are you addicted? _______Detoxed? ______

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REVIEW OF SYSTEMS

Please circle those that apply or check the "none" box

GENERAL
Fever, Night Sweats
Marked Weight gain/loss
None☐

HEAD, EYES, EARS, NOSE
Frequent headaches
Neck pain/stiffness
Glaucoma
Blurring/vision
Dizziness
Hearing problems
Sinus problems
None☐

CHEST/RESPIRATORY
Asthma
Sputum production from cough
Cough up blood
Chronic cough
Positive TB skin test
Abnormal Chest X-ray
None☐

CARDIAC
High Blood Pressure
History of Heart attack
Chest Pain
Rapid/Abnormal Pulse
Ankle Swelling
None☐

VASCULAR
Previous phlebitis
Leg cramps on exercise
Varicose veins
Poor circulation
None☐

GASTROINTESTINAL
Ulcers/gastritis
Severe/frequent abdominal pain
Tarry/Black bowel movements
Yellow/Jaundice
Vomit blood, Hepatitis
None☐

GYNECOLOGICAL/WOMEN
Pregnant now? ________
Abnormal/irregular periods
Date last period________
Age periods stopped___
None☐

MUSCULOSKELETAL
General joint pain/arthritis
Joint swelling
Spinal pain
None☐

ENDOCRINE
Diabetes
Thyroid abnormality
Gout
Osteoporosis
None☐

NEUROLOGICAL
Fainting
Convulsions
Dizziness
Shakiness/trembling
Diffuse muscle weakness
Tingling in extremities
None☐

URINARY
Kidney Stones
Blood in your urine
Frequent/Painful urination
Recurrent Kidney/Bladder infections
None☐

PSYCHIATRIC
Psychiatric Hospitalization
Depression
Frequent Mood Swings
History of substance abuse
None☐

OTHER
AIDS/HIV
Tested positive for HIV? Yes☐ No☐ When? ________

I attest that the above information is true and correct to the best of my knowledge and recollection.

Signature of Patient or Legal Representative______________________________ **Date**________________