

Southern Bone & Joint

1500 Ross Clark Circle, Dothan, AL / 345 Healthwest Drive, Dothan, AL / 404 North Main, Enterprise, AL

HEALTH HISTORY

Name: _____ Age: _____ Date: _____

Weight: _____ Height: _____ Dominant Hand: _____ Allergies: _____

Reason For Visit: _____

Describe Problem (where, how long, what makes it better/worse, etc.): _____

On a scale of 0-10 (10 is the worst) how **severe** is your pain (circle) 0 1 2 3 4 5 6 7 8 9 10

What is the **quality** of the pain? Sharp Dull Stabbing Throbbing Aching Burning

The pain is Constant Comes and Goes (Intermittent). Does your pain wake you from sleep? Yes No

Since my problem started, it is: Getting better Getting worse Unchanged

Date of Accident or **ONSET DATE**: _____

Type of Injury: _____ Auto _____ Home _____ Other _____ Workmen's Compensation

If WC give name and address of Company: _____

REFERRAL DOCTOR &/OR FAMILY PHYSICIAN: _____

Past Surgical History:

Date Physician

Past Medical History (CHECK IF APPLICABLE)

Medications

____ Heart _____ : _____
____ High Blood _____ : _____
____ Lung (general) _____ : _____
____ Tuberculosis _____ : _____
____ Cancer _____ : _____
____ Seizures _____ : _____
____ Stomach Ulcers _____ : _____
____ Diabetes _____ : _____
____ Gout _____ : _____
____ Rheumatoid Arthritis _____ : _____
____ Other (_____) _____ : _____

Social History

Do you use tobacco? Yes No Packs per day _____ Alcohol use? Yes No How Often? _____
Daily Other _____/week

Marital History: M S D W

Occupation: _____ Student Employer: _____

Family History: Have any direct relatives had any of the following disorders? If so, which relative?

Diabetes _____ High Blood Pressure _____
 Heart disease _____ Rheumatoid Arthritis _____ None _____

Do any direct relatives have the same condition you are being seen for today? Y N

(relation to you) _____