SIDELINE ORTHOPEDICS AND SPORTS MEDICINE

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New Patient Medical History for HIP Symptoms

Name:_____ Today's Date: _____
Age:_____ Phone number: _____
Referred by:_____ Date of Injury/Onset of symptoms: _____

Reason for visit. Describe injury or onset in detail: ❑ LEFT ❑ RIGHT _____

_____

_____

_____

Pain: ❑ Sharp ❑ Dull ❑ Stabbing ❑ Burning ❑ Other: _____
❑ Constant ❑ Intermittent **Intensity:** 0—1—2—3—4—5—6—7—8—9—10
Location: _____
Does the pain go anywhere else (describe)? _____
What makes pain worse? ❑ Standing ❑ Walking ❑ Running ❑ Stairs ❑ Squatting
❑ Pivoting ❑ Sitting ❑ Other: _____
What makes pain better? ❑ Rest ❑ Activity Modification ❑ Ice/Heat ❑ Meds
❑ Other: _____
What other symptoms are present? ❑ Catching ❑ Popping ❑ Grinding ❑ Locking ❑ Giving way
❑ Back pain ❑ Numbness/tingling
What treatments have you attempted and what effect? (PT, meds, injections) _____

_____

Can you work or participate in sports with current symptom? ❑ NO ❑ YES
Do you have light duty available at work? ❑ NO ❑ YES

Past Medical and Family History (check all that apply ❑ **You** ❑ **Family History**)

❑ ❑ High Blood Pressure	❑ ❑ Heart Disease	❑ ❑ Stroke	❑ ❑ Diabetes
❑ ❑ COPD	❑ ❑ Asthma	❑ ❑ Reflux	❑ ❑ Ulcers
❑ ❑ Kidney Disease	❑ ❑ Vascular Disease	❑ ❑ Hepatitis	❑ ❑ Blood Clots
❑ ❑ Bleeding Disorder	❑ ❑ Cancer	❑ ❑ Arthritis	❑ ❑ Seizures
❑ ❑ Headaches	❑ ❑ HIV		

❑ ❑ Other: _____

Past Surgical History ❑ (check all that apply)

❑ Appendectomy	❑ Gall Bladder	❑ Hernia	❑Breast
❑ Heart Bypass	❑ Heart Valve	❑ Pacemaker	❑Spine/Neck
❑ Arthroscopy	❑ Joint Replacement	❑ Rotator Cuff	❑Hysterectomy

❑ Other: _____

Drug Allergies (list all known drug allergies)

_____

_____

Please complete both sides of form, sign and date.

Medications: (please list all prescription and over the counter medications and supplements)

❑ Separate List Attached

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Social History

❑ Single ❑ Married ❑ Divorced ❑ Widowed Children? ❑ NO ❑ YES # _____

Do you smoke? ❑ NO ❑ YES_____packs per day

Do you drink alcohol? ❑ NO ❑ YES Do you use drugs? ❑ NO q YES (list) _____

What is your occupation? _____

Do you exercise regularly? ❑ NO ❑ Yes _____days per week

Do you participate in sports? ❑ NO ❑ YES (list) _____

Review of Systems

Do you currently or frequently have: ❑ (check all that apply)

Constitutional
- ❑ Weight loss
- ❑ Weight gain
- ❑ Fever
- ❑ Chills

Eyes
- ❑ Blurred vision
- ❑ Double vision

Ears, Nose, Throat
- ❑ Hearing loss
- ❑ Ringing in ears
- ❑ Congestion
- ❑ Sore throat

Respiratory
- ❑ Shortness of breath
- ❑ Wheezing
- ❑ Cough
- ❑ Coughing blood

Cardiovascular
- ❑ Chest pain
- ❑ Palpitations

Genitourinary
- ❑ Painful urination
- ❑ Blood in urine
- ❑ Urgency/frequency
- ❑ Incontinence

Gastrointestinal
- ❑ Nausea
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Constipation
- ❑ Incontinence

Skin
- ❑ Rash
- ❑ Skin lesion
- ❑ Nail problems

Neurological
- ❑ Headaches
- ❑ Seizures
- ❑ Dizziness
- ❑ Balance problems
- ❑ Numbness/tingling
- ❑ Weakness

Endocrine
- ❑ Thirst
- ❑ Tired/sluggish
- ❑ Hot
- ❑ Cold

Hematologic
- ❑ Bleeding problems
- ❑ Bruising
- ❑ Limb swelling

Psychiatric
- ❑ Depression
- ❑ Anxiety
- ❑ Insomnia
- ❑ Addiction
- ❑ Drug use

Musculoskeletal (other than current complaint)
- ❑ Joint pain (list) _____

_____

_____
- ❑ Back pain
- ❑ Neck pain
- ❑ Joint stiffness
- ❑ Joint swelling
- ❑ Gout

Other Medical Concerns: (list)

_____

_____

_____

_____

Height: _____

Weight: _____

Patient Signature:_____ Date: _____

Provider Signature:_____ Date: _____