Orthopedic Specialists of North Texas
Michael A. House, MD

Name_____ Date_____ Ht_____ Wt_____ Age_____
Date of Injury_____ Referred By_____ Family Physician _____
Chief Complaint_____ Pain Scale (1 to 10, 1 being least amount of pain) _____
Alleviating Factors _____ Aggravating Factors_____
Details of Injury (How? Where? Any Treatment?)_____
_____
_____
Medical History (High Blood Pressure, Diabetes, Emphysema, Gastric Reflux, etc.) _____
_____

MEDICATIONS

FAMILY HISTORY			
Member	Alive/Dead	Age	Health Status
Grandmother (mom's)	A D		
Grandfather (mom's)	A D		
Grandmother (dad's)	A D		
Grandfather (dad's)	A D		
Father	A D		
Mother	A D		
Sister/Brother	A D		
Sister/Brother	A D		
Sister/Brother	A D		
Sister/Brother	A D		

HOSPITALIZATIONS OR SURGERY	Year	Surgeon/Hospital

DRUG ALLERGIES
_____
_____
_____
_____
_____

Have you ever had general anesthesia? Y / N Have any problems with anesthesia? Y / N _____

REVIEW OF SYSTEMS: (Please check if you are currently or have had problems with these & describe)
Eyes _____ Diabetes_____ Arthritis_____
Ears,Nose,Throat_____ High Blood Pressure_____ Strokes_____
Lungs,Breathing_____ Bleeding Problems_____ Hepatitis_____
Chest Pain/Heart Problems_____ Balance Problems_____ Tuberculosis_____
Ulcers_____ Numbness/tingling_____ Seizures_____
Bowel Movement_____ Blackout/fainting_____ Blood Clots_____
Bladder Problem_____ Depression_____ Cancer_____

SOCIAL HISTORY:
Marital Status: S M D W Do you live alone? Y / N Exercise Regularly (times/week)_____ Type_____
Smoke: Y / N Packs per day_____ How many years_____ Alcohol use: Y / N Drinks per day_____
Drug use: Y / N What? _____ Years_____ Drug Rehab: Y / N
Do you use assistive device (cane, walker, etc.) for ambulation? Y/N
If yes, what type and how long? _____
Occupation_____ Who do you work for? _____
Where do you live? (Home, Nursing Home, Relatives, etc.) _____

Signature:_____

Physician Notes: