OLSEN ORTHOPEDICS

PATIENT HISTORY

Name _____ Date of Birth _____

What are you being treated for (body part)? _____ Right Left

Are you here for a 2nd opinion? Y N **Date of Injury** _____

SOCIAL HISTORY

Alcohol YES NO How often? _____

Children YES NO How many? _____

Highest Education Kind. 1 2 3 4 5 6 7 8 9 10 11 12 college Associates Bachelors Masters

Occupation FT PT Student Retired Homemaker Self Employed Unemployed

Do you exercise? YES NO How often? _____

Marital Status Single Married Divorced Widowed

Smoke YES NO Cigars Cigarettes

How much per day? _____

Previous smoker? YES NO Quit Date: _____

Dip / Chew YES NO

How much per day? _____

Spoken language: _____

Race: _____ Ethnicity: _____

FAMILY HISTORY *(indicate relative)*

Alzheimers	_____	Heart Attack	_____
Arthritis	_____	Heart Disease	_____
Blood Clots	_____	High Blood Pressure	_____
Cancer	_____	High Cholesterol	_____
Depression	_____	Stroke	_____
Diabetes	_____	Other	_____

(Personal health/illness info on next page)

Patient Signature: _____ Date: _____

Patient Name: _____ **DOB:** _____

Name of Pharmacy: _____

Location: _____

What are you being seen for today? How / When did this happen? _____

Do you have a pain management doctor? **YES** **NO**

If YES… Who? _____

Is this an on-the-job injury?	**Y**	**N**	*Is this due to a motor vehicle accident?*	*Y*	*N*
Have you been treated for this injury?	Y	N	**Do you have an attorney handling this claim?**	Y	N
Was surgery performed?	Y	N	Did you bring x-rays or MRI with you?	Y	N

Are you currently diagnosed with any illnesses?

Drug Allergies?

Previous Surgeries?

Currently taking any medications? (list name and dosage)

Patient Signature: _____ Date: _____