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: ______________