

Patient Name: _____

Social History

Are you: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/>
Living Arrangements: <input type="checkbox"/> Home alone <input type="checkbox"/> Home with Spouse <input type="checkbox"/> Assisted Living <input type="checkbox"/> Nursing Home <input type="checkbox"/>
Do you presently smoke tobacco? Yes <input type="checkbox"/> No <input type="checkbox"/> If no, have you ever smoked Yes <input type="checkbox"/> No <input type="checkbox"/> When did you quit? If yes, please list the amount you smoke _____ pack / day _____ packs / week _____ Number of years smoked
Do you drink alcohol regularly? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please list the amount and type ingested per day: _____
Pharmacy/Location _____ Cardiologist _____
Home Health _____ Physical Therapist _____

Problem

What are you seeing the doctor for today? _____

How long have you had these symptoms: _____

Date of accident or injury: _____

Where did it occur? _____

How did the accident happen? _____

Who, if anyone, has been treating you for this problem? _____

What treatment, if any, have you had? _____

Have you had any x-rays for this problem? _____

When? _____ Where? _____

Have you had a CT Scan, Myelogram or MRI for this problem? _____

When? _____

Where? _____

Nerve Study _____ When? _____

Where? _____

Referring Physician _____

Medications

Drug	Dosage	Drug	Dosage
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

Allergies Do you have a history of latex allergy? Yes No

Drug	Reaction	Drug	Reaction
1.		6.	
2.		7.	

HOUMA
Orthopedic
CLINIC

A Medical Corporation

Patient's Name: _____

Using the following symbols, please mark all the appropriate areas of your body that are affected by the corresponding sensations:

ACHING

++++++

++++++

NUMBNESS

PINS & NEEDLES

0000000000000000

0000000000000000

BURNING

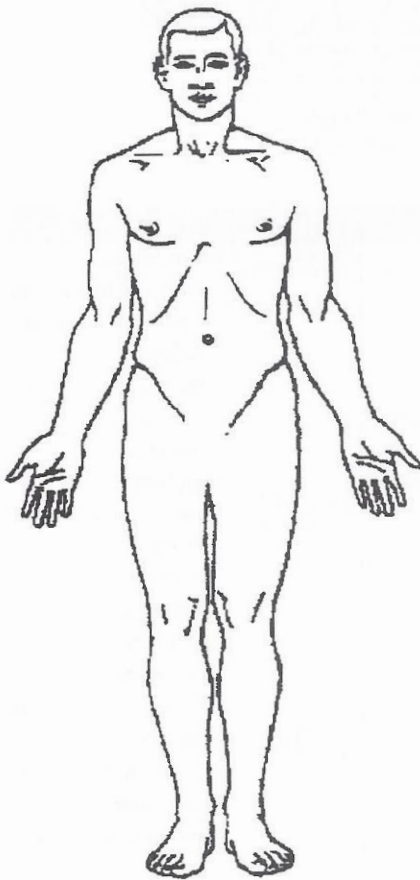
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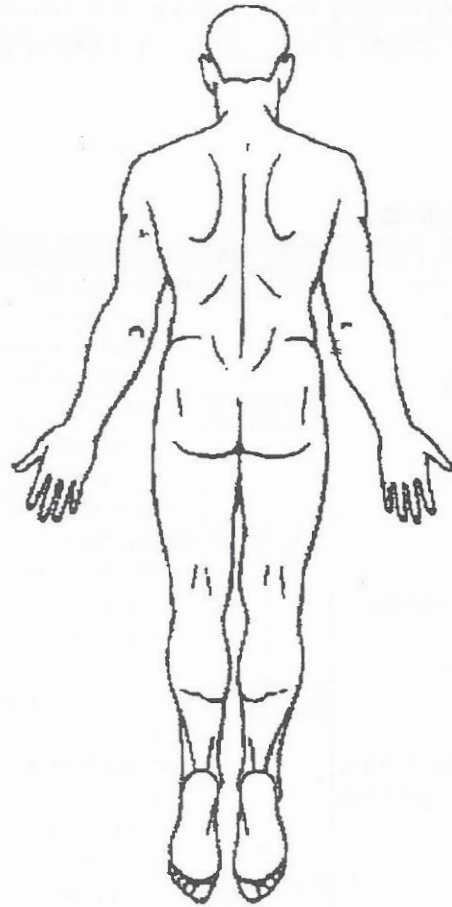
STABBING

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FRONT



BACK