Beacon Orthopaedics & Sports Medicine, Ltd.
PATIENT HISTORY

Name_____ Age_____ DOB_____ Date_____

Chief Complaint_____

Was this due to an injury or accident? Yes ☐ No ☐ Date of Injury _____ Did this occur at work? Yes☐ No☐

Has this injury been treated? Yes ☐ No ☐ If yes, how has this been treated and by whom? _____

_____

Have you had a previous similar injury? Yes☐ No☐ Please explain _____

Current weight _____ 1 Year Ago _____ Height _____ Blood Pressure: _____ Occupation _____

Marital Status S ☐ M ☐ W ☐ D ☐ Do you live alone? Yes ☐ No ☐ Hobbies/ Sports _____

Do you smoke? Yes ☐ No ☐ If yes, how many per day? _____

Do you consume alcohol? Yes ☐ No ☐ If yes, how much per week? _____

Name of Primary Care Physician _____

Drug Allergies _____

Current Medications _____

_____

Hospitalizations or surgeries? _____ _____

_____ _____

Have you ever had a blood transfusion? Yes ☐ No ☐ If yes, date _____

PLEASE USE BACK OF FORM TO ADD ANY OTHER PERTINENT INFORMATION

Have you or your family members had any of the following conditions? (Please check all that apply)

	SELF		MOTHER		FATHER		CHILDREN/ OTHER	
	Yes	No	Yes	No	Yes	No	Yes	No
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐
Epilepsy/ Convulsions	☐	☐	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐	☐	☐

FOR WOMEN ONLY:
Pregnant Yes ☐ No ☐

Are there any other serious illnesses/health conditions affecting you or your family of which we should be aware? Yes ☐ No ☐

_____
_____
_____
_____
_____
_____

Please check if you have ever had the symptom listed – Check all that apply

CONSTITUTIONAL
☐ Fever
☐ Weight Loss
☐ Fatigue

EYES
☐ Double Vision
☐ Blurring
☐ Trauma

ENT/MOUTH
☐ Deafness
☐ Sinusitis
☐ Ringing in Ears
☐ Dizziness
☐ Balance Problems

CARDIOVASCULAR
☐ Chest Pain
☐ Heart Murmur
☐ High Blood Pressure
☐ Heart Attach
☐ Irregular Rhythm

RESPIRATORY
☐ Shortness of Breath
☐ Asthma
☐ Lung Disease
☐ Bronchitis
☐ Pneumonia

GI
☐ Weight Change
☐ Diarrhea
☐ Constipation
☐ Ulcer
☐ Gallbladder Disease
☐ Change in Bowel Habits

GU
☐ Leaking Urine
☐ Prostate Disease
☐ Pain with Urination
☐ Frequent Urination
☐ Kidney Stones

MUSCULOSKELETAL
☐ Fracture
☐ Pain
☐ Swelling
☐ Arthritis
☐ Spasm/Muscle
☐ Gout
☐ Rheumatoid Arthritis

NEUROLOGICAL
☐ Seizures/ Epilepsy
☐ Weakness
☐ Stroke
☐ Headaches
☐ Blackouts/Fainting
☐ Tremble
☐ Head Injuries

PSYCH
☐ Depression
☐ Sleep Disorder
☐ Memory Problems

VASCULAR
☐ Blood Clots
☐ Poor Circulation

HEMATOLOGIC
☐ Hepatitis
☐ Anemia
☐ Lymph Node
☐ AIDS

ALLERGY/IMMUNOLOGY
☐ Hay Fever
☐ Dermatitis

SKIN/BREAST
☐ Breast Abnormality
☐ Change in Skin/Hair

Patient Signature _____ Date _____

Reviewed By _____ M.D. Date _____

NOTE: This is a confidential record of your medical history and will be maintained in the office.
The information contained herein will not be released to any person except when you have authorized us to do so.