

PALM BEACH ORTHOPAEDIC INSTITUTE, P.A.
HISTORY FORM – FOLLOW UP

Chief Complaint: _____ Date of Injury: _____
W: _____ lbs H: _____ Age: _____

FIELDS MARKED WITH AN ASTERISK (*) ARE FEDERAL REQUIREMENTS.

*DOB: _____ *Sex: Male Female *Smoking: Smoker Nonsmoker Former Smoker

*** SINCE YOUR LAST VISIT, please list any CHANGES to your Current Medications, Vitamins & Supplements:**

No Medications

Pharmacy | Location: _____

*** SINCE YOUR LAST VISIT, please list any CHANGES to your Allergies:**

None Known Codeine Iodine Sulfa Aspirin Penicillin Demerol Adhesive/Tape

Other: _____

History of Present Illness

*Please check the appropriate box(es) below and/or add any additional information needed.

- Where is your injury / problem / pain (body part)? _____
- Has your current problem become:
 worse better more frequent stayed the same other: _____
- How often do you experience the symptoms/pain/problem?
 constantly off and on during activity/sports/exercise at night other: _____
- Are you or have you experienced any:
 bruising swelling redness rashes ringing numbness weakness other: _____
- What level of pain do you experience (circle)? 0 1 2 3 4 5 6 7 8 9 10
- Have you found anything that helps to improve the symptoms/pain/problem?
 ice heat rest elevation therapy medication other: _____

Past Medical History

SINCE YOUR LAST VISIT have there been any CHANGES in your health:

Please explain: _____

Please list any surgical procedures or hospitalizations **SINCE YOUR LAST VISIT:**

Review of Systems

SINCE YOUR LAST VISIT have there been any CHANGES in your health:

- | | | | |
|-----------------------------|-----------------------------|------------------------------|----------------|
| Respiratory Problems? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Explain: _____ |
| Cardiovascular Problems? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Explain: _____ |
| Gastrointestinal Problems? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Explain: _____ |
| Genital / Urinary Problems? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Explain: _____ |
| Neurological Problems? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Explain: _____ |
| Emotional Problems? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Explain: _____ |
| Bleeding Disorders? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Explain: _____ |
| Skin Problems? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Explain: _____ |
| Eye Problems? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Explain: _____ |

