

Jeffrey D. Harrison, M.D.  
 Craig C. Pulley, PA-C

PATIENT HISTORY		
Welcome to the Calton-Harrison Clinic. Please complete this past medical history form accurately to help us serve you better. This information is very important to your care, please be as accurate as possible. <b>Print this form and bring it with you to your appointment. Thank you.</b>		
Name:		Date:
Age:	Height:	Weight:
Occupation:		
Primary care physician:		
Who referred you to our office?		
Have you seen any other orthopedic surgeons for this condition? If YES, who?		
Please list recreational activities you enjoy:		
HISTORY OF INJURY		
Which body part is injured?		Right or Left
What was the date of injury or onset of symptoms?		
Describe how this happened / began:		
Did this occur at work or in an auto accident?		
Is the pain: <input type="checkbox"/> Constant <input type="checkbox"/> Occasional <input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Stabbing <input type="checkbox"/> Throbbing		
Describe WHERE the pain is the worst:		
What makes your symptoms worse?		
What makes your symptoms better?		
Rate your PAIN intensity on a scale of 1-10 (10 being the worst): AT REST: 1 2 3 4 5 6 7 8 9 10 AT ITS WORST: 1 2 3 4 5 6 7 8 9 10		
Rate the overall FUNCTION of the injured joint on a scale of 1-10 (10 being perfect): 1 2 3 4 5 6 7 8 9 10		
What symptoms are you having? <input type="checkbox"/> Swelling <input type="checkbox"/> Pain at night <input type="checkbox"/> Pain with stairs <input type="checkbox"/> Pain with standing for long periods <input type="checkbox"/> Giving way <input type="checkbox"/> Popping <input type="checkbox"/> Catching <input type="checkbox"/> Grinding <input type="checkbox"/> Weakness <input type="checkbox"/> Instability <input type="checkbox"/> Stiffness <input type="checkbox"/> Numbness/tingling		
Are you right or left hand dominant? <input type="checkbox"/> Right <input type="checkbox"/> Left		
Have you had any previous surgery on this body part? <input type="checkbox"/> NO <input type="checkbox"/> YES – What: _____ When: _____ Surgeon: _____		
Have you had any steroid injections in this joint? <input type="checkbox"/> NO <input type="checkbox"/> YES – How many: _____ When: _____ Physician: _____		
Have you tried any anti-inflammatories? <input type="checkbox"/> NO <input type="checkbox"/> YES – What?		
Have you had any recent physical therapy for this condition? <input type="checkbox"/> NO <input type="checkbox"/> YES _____ (# of visits)		
Have you had any other treatments?		
Have you had any of the following for this injury? <input type="checkbox"/> X-ray <input type="checkbox"/> MRI <input type="checkbox"/> CT scan <input type="checkbox"/> EMG <input type="checkbox"/> Arthrogram If YES, where?		

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<b>ALLERGIES</b>
Please list any medications you are allergic to:
<input type="checkbox"/> No known drug allergies
Are you allergic to: <input type="checkbox"/> Latex <input type="checkbox"/> IV dye <input type="checkbox"/> Iodine / Betadine <input type="checkbox"/> Tape <input type="checkbox"/> Sulfa <input type="checkbox"/> Steroids
Have you ever had a serious reaction or complication from anesthesia? <input type="checkbox"/> NO <input type="checkbox"/> YES – What?
Has a blood relative had a serious reaction or complication from anesthesia? <input type="checkbox"/> NO <input type="checkbox"/> YES – What?

<b>MEDICATIONS</b>																		
Please list all medications you are currently taking, including dosage and frequency (include insulin and blood thinners):																		
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<b>PAST MEDICAL HISTORY</b>																																							
Check if you currently suffer of have previously suffered from:																																							
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<b>PAST SURGICAL HISTORY</b>															
Please list all surgeries you've had in the past and the year performed															
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FAMILY HISTORY					
Please check immediate family history conditions:					
<input type="checkbox"/>	Blood clots	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Hypertension
<input type="checkbox"/>	Cancer: _____	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	Heart attack	<input type="checkbox"/>	Dialysis	<input type="checkbox"/>	Bleeding problems

SOCIAL HISTORY	
Marital status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
If you were to be recovering from surgery, is there someone to assist you at home? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Tobacco use: <input type="checkbox"/> NO <input type="checkbox"/> YES – Frequency: _____ # of years _____	
Alcohol use: <input type="checkbox"/> NO <input type="checkbox"/> YES – Frequency: _____	
Recreational drug use: <input type="checkbox"/> NO <input type="checkbox"/> YES – Frequency: _____	

REVIEW OF SYSTEMS					
Check if you currently suffer or have previously suffered from problems related to the following systems:					
<b>CONSTITUTIONAL</b>		<b>EYES</b>		<b>NEUROLOGICAL</b>	
<input type="checkbox"/>	Recent weight change	<input type="checkbox"/>	Vision change	<input type="checkbox"/>	Fainting
<input type="checkbox"/>	Chills	<input type="checkbox"/>	Pain	<input type="checkbox"/>	Numbness
<input type="checkbox"/>	Fever	<input type="checkbox"/>	Double vision	<input type="checkbox"/>	Tingling
<b>ENDOCRINE</b>		<b>GASTROINTESTINAL</b>		<b>Loss of sensation in any area</b>	
<input type="checkbox"/>	Excessive thirst	<input type="checkbox"/>	Abdominal pain	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	Hot / cold intolerance	<input type="checkbox"/>	Nausea / vomiting	<input type="checkbox"/>	Headaches
<input type="checkbox"/>	Excessive fatigue	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	
<b>CARDIOVASCULAR</b>		<b>SKIN</b>		<b>MUSCULOSKELETAL</b>	
<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	Rash	<input type="checkbox"/>	Swelling of joints
<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	Persistent itch	<input type="checkbox"/>	Muscle aches
<input type="checkbox"/>	Palpitations	<input type="checkbox"/>	Abnormal scars	<input type="checkbox"/>	Neck pain
<input type="checkbox"/>	Swelling in legs	<input type="checkbox"/>	Skin infections	<input type="checkbox"/>	Back pain
<input type="checkbox"/>	Fainting	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	
<b>EARS / NOSE / THROAT</b>		<b>GENITOURINARY</b>		<b>RESPIRATORY</b>	
<input type="checkbox"/>	Loss of hearing	<input type="checkbox"/>	Painful urination	<input type="checkbox"/>	Wheezing
<input type="checkbox"/>	Ear infection	<input type="checkbox"/>	Urinary frequency	<input type="checkbox"/>	Frequent cough
<input type="checkbox"/>	Soar throat	<input type="checkbox"/>		<input type="checkbox"/>	Shortness of breath
<b>HEMATOLOGIC / LYMPHATIC</b>		<b>PSYCHIATRIC</b>			
<input type="checkbox"/>	Easy bruising	<input type="checkbox"/>	Depression	<input type="checkbox"/>	
<input type="checkbox"/>	Easy bleeding	<input type="checkbox"/>	Ever considered suicide	<input type="checkbox"/>	
<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Severe mood swings	<input type="checkbox"/>	
<input type="checkbox"/>	Swollen glands	<input type="checkbox"/>	Addiction	<input type="checkbox"/>	

PATIENT SIGNATURE	
This information is true to the best of my knowledge.	
Patient Name (print): _____	
Patient / Guardian Signature: _____	
Date: _____	

**IMPORTANT - Bring previous x-rays, MRI films and radiology report with you to your appointment.**