BRIGHAM AND WOMEN'S HOSPITAL

PATIENT DEMOGRAPHICS

Patient Name:_____ Date of Birth: _____

Phone : _____ Best time to call: _____

PRIMARY CARE MD:_____ **REFERING MD:**_____

Address: _____ Address: _____

_____ _____

Phone: _____ Phone: _____

PRESENT HISTORY

Chief Complaint**:**_____

Reason for today's visit:_____

How long have you had this problem?_____

What makes your problem better / worse?_____
(lying, bending, sneezing, standing, lifting, walking, sitting, coughing) or (rest, exercise, sitting, lying down, other)

Current Limitations:_____

Current problem is the result of a(n): ____ Car Accident ____Work Accident ____Accident ____Other
(Check all that apply)

Date of Injury:_____

PAST HISTORY

Please list any prior illnesses and /or injuries:

_____

_____

Previous treatments other than surgery:_____

Previous surgery for this problem:_____

Are you under the care of a Cardiologist**:**____Yes ____No Name:_____

Address/Location: _____ Phone: _____

_____ State _____ Zip_____

Have you ever had problems with anesthesia in the past? ____Yes ____No

If yes, please explain:_____

SURGICAL HISTORY

SURGERIES / HOSPITALIZATIONS	YEAR	COMPLICATIONS

MEDICATIONS

CURRENT MEDICATION(S)	DOSE	FREQUENCY

Allergies to Medications:

_____

_____

FAMILY HISTORY

Is there any history in your family of

Gout: ____No ____Yes, Who?_____

Rheumatoid Arthritis: ____No ____Yes, Who?_____

Cardiac Issues: ____No ____Yes, Who?_____

Other Significant Orthopedic Problems: ____No ____Yes, Who?_____

SOCIAL HISTORY

Occupation:_____

How long have you been at your current job?_____

Marital Status: ___Single ___Married ___Divorced ___Widowed

Do you have children? ___Yes ___No How many? _____

Do you live alone? ___Yes ___No Who lives with you?_____

Do you smoke?

___Yes, I've smoked _____packs of cigarettes per day for ___years.
___Yes, I smoke cigars or a pipe.
___No, I have never smoked.
___No, I quit ____years ago. At that time I was smoking ____packs per day for ____years.

Do you drink alcohol?
___No, never (or rarely)
___No, but I used to
___Yes How Often? ___Daily ___1 or more times/week ____1 or more times/month

Have you lost or gained more than 10 pounds in the last 3 months without trying or wanting to lose weight? **YES** **NO**

Do you exercise regularly? **YES** **NO**

What exercise do you do? _____

How Often?_____

Have you had any problems eating or drinking foods recently (e.g. poor appetite, difficulty chewing or swallowing? **YES** **NO**

Is there anything that restricts you from doing the activities you want to do? **YES** **NO**

REVIEW OF SYSTEMS

Are you currently, or have you ever had problems with:

CONSTITUTIONAL	CIRCLE ONE	
Fever	Yes	No
Unexpected Weight Loss	Yes	No
Excessive Fatigue	Yes	No
Night Sweats	Yes	No
Loss of appetite	Yes	No
EYES		
Wear Glasses or Contacts	Yes	No
Infections	Yes	No
Injuries	Yes	No
EAR, NOSE, THROAT & MOUTH		
Wear Hearing Aids?	Yes	No
Date of last Exam:_____		
Hearing Loss	Yes	No
Ear Infections	Yes	No
Balance Disturbance	Yes	No
Sinus Problems	Yes	No
CARDIOVASCULAR		
Chest Pain or Angina	Yes	No
Date of Last EKG:_____		
High Blood Pressure	Yes	No
Irregular Pulse	Yes	No
Heart Murmur	Yes	No
Heart Attack	Yes	No
Blood Clots	Yes	No
RESPIRATORY		
Asthma	Yes	No
Chronic Cough	Yes	No
Emphysema	Yes	No
Shortness of Breath	Yes	No
Bronchitis	Yes	No
Pneumonia	Yes	No
Lung Cancer	Yes	No
Tuberculosis	Yes	No

GASTROINTESTINAL	CIRCLE ONE	
Nausea	Yes	No
Vomiting	Yes	No
Ulcers or Gastritis	Yes	No
Colon Cancer	Yes	No
Stomach Ulcer	Yes	No
Hepatitis	Yes	No
GENITOURINARY		
Urinary Tract Infections	Yes	No
Kidney Stones	Yes	No
Kidney Disease	Yes	No
MUSCULOSKELETAL		
Broken Bones	Yes	No
List:_____		
Arm or Leg Weakness	Yes	No
Back Pain	Yes	No
Arm or Leg Pain	Yes	No
Joint Pain or Swelling / Arthritis	Yes	No
Numbness	Yes	No
Osteoporosis	Yes	No
Instability / giving way / dislocatio	Yes	No
Stiffness	Yes	No
Scolosis	Yes	No
Spinal Conditions	Yes	No
INTEGUMENTARY		
Skin Cancer	Yes	No
Skin Ulcers	Yes	No
NEUROLOGICAL		
Fainting Spells or "Blacking Out"	Yes	No
Seizures	Yes	No
Coordination in Arm and / or Legs	Yes	No
Stroke	Yes	No
Balance Problem	Yes	No
Headaches	Yes	No

ENDOCRINE	CIRCLE ONE	
Diabetes	Yes	No
Treatment:_____		
Thyroid Disease / Disorder	Yes	No
Hormone Problems	Yes	No
HEMATOLOGIC / LYMPHATIC		
Anemia	Yes	No
Hemophilia	Yes	No
Bleeding Tendencies	Yes	No
Persistent Swollen Glands/Lymph Nodes	Yes	No
Blood Transfusion	Yes	No
If yes, when?_____		
Easy bleeding	Yes	No
Easy bruising	Yes	No
Cancer	Yes	No
ALLERGIC / IMMUNOLOGIC		
Inhalant (Nasal) Allergies	Yes	No
Immunologic Disorders	Yes	No
PSYCHIATRIC		
Anxiety	Yes	No
Depression	Yes	No
Other Psychiatric Disorder	Yes	No
Treatment:_____		

The above information is accurate to the best of my knowledge.

_____

Patient Signature *Date*

I have reviewed the above information with the patient.

_____

Physician's name *Date*

_____

Physician's signature