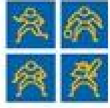

All-Star Orthopaedics and Sports Medicine

Patient Name: ______________________ Date of Birth: __________ Date of Visit: __________

Primary Care Physician: ______________________ Referred by: ______________________

H & P Ortho Bubblesheet

Please indicate answers by completely filling in the applicable circles.

Are you, or could you be, pregnant?	O **YES**	O **NO**	**If YES, notify the X-RAY technician as soon as possible.**

Past Medical History

In general, your health is (mark one): O Excellent O Good O Fair O Poor O Terrible

Have you ever had cortisone or steroid injections? O Yes O No

Please indicate past medical history below (mark all that apply):

O AIDS/HIV	O alcoholism	O Alzheimer's disease	O anemia
O anxiety	O asthma/breathing problems	O bleeding problems	O blood clots
O cancer	O depression	O diabetes	O epilepsy/seizures
O fibromyalgia	O fractures	O gall bladder disease	O glaucoma
O gout	O heart disease	O hepatitis	O high blood pressure
O high cholesterol	O irritable bowel syndrome	O kidney disease	O liver disease
O lung disease	O migraines	O mitral valve prolapse	O mononucleosis
O neuropathy	O osteoporosis	O Parkinson's disease	O phlebitis
O pneumonia	O polio	O rheumatic fever	O rheumatoid disease
O stroke	O thyroid disease	O tuberculosis	O ulcer
O varicose veins	O venereal disease	O sleep apnea (w/ C-PAP)	O sleep apnea (w/o C-PAP)

Current Symptoms or Problems / Review of Systems

Change in appetite	O Yes	O No	Chills	O Yes	O No	Fatigue	O Yes	O No
Fever	O Yes	O No	Headache	O Yes	O No	Lightheadedness	O Yes	O No
Night sweats	O Yes	O No	Sleep disturbance	O Yes	O No	Weight gain	O Yes	O No
Weight loss	O Yes	O No	Cough	O Yes	O No	Itching	O Yes	O No
Rash	O Yes	O No	Blurred vision	O Yes	O No	Difficulty swallowing	O Yes	O No
Sore throat	O Yes	O No	Cold intolerance	O Yes	O No	Difficulty sleeping	O Yes	O No
Dizziness	O Yes	O No	Excessive thirst	O Yes	O No	Frequent urination	O Yes	O No
Chest pain	O Yes	O No	Irregular heartbeat	O Yes	O No	Shortness of breath	O Yes	O No
Palpitations	O Yes	O No	Decreased appetite	O Yes	O No	Easy bruising	O Yes	O No
Prolonged bleeding	O Yes	O No	Painful joints	O Yes	O No	Swollen joints	O Yes	O No
Leg cramps	O Yes	O No	Joint stiffness	O Yes	O No	Sciatica	O Yes	O No
Ulceration of feet	O Yes	O No	Skin Cancer	O Yes	O No	Low back pain	O Yes	O No
Memory loss	O Yes	O No	Seizures	O Yes	O No	Tingling/Numbness	O Yes	O No
Balance difficulty	O Yes	O No	Gait abnormality	O Yes	O No	Suicidal thoughts	O Yes	O No
Eating disorder	O Yes	O No						