ORTHOPAEDIC INSTITUTE
of Chattanooga

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Patient History Sheet

Date: ____________________

Patient Name: ____________________ Date of Birth: __________ Age: __________

Primary Care Physician: ____________________ Referring Physician: ____________________

Please describe your illness or injury in detail: ____________________

____

Date of Injury: __________ Location Injury Occurred: ____________________

Please check any illnesses you have currently or have had in the past:

☐ Heart Problems ☐ Lung Disease ☐ Diabetes ☐ Reflux/GERD ☐ Arthritis

☐ High Cholesterol ☐ Asthma ☐ Neurological ☐ Liver Disease ☐ Cancer

☐ High Blood Pressure ☐ Thyroid ☐ Ulcers ☐ Kidney Problems ☐ Blood Clots/Bleeding

Others: ____________________

Please check any family illnesses or conditions:

☐ Arthritis ☐ Diabetes ☐ Heart ☐ High Blood Pressure ☐ Cancer ☐ Blood Clots/Bleeding

Other: ____________________

Please list any Medications, Vitamins, Herbs and Diet Pills you are currently taking:

1.	5.	9.
2.	6.	10.
3.	7.	11.
4.	8.	12.

Please list any medication allergies: ____________________

Please list any allergies to Jewelry or Metals: ____________________

Please list any history of orthopaedic surgeries or conditions with dates/year:

____

____

Please list any history of other previous surgeries with dates/year:

____

____

How much do you smoke/tobacco use? ______ Any alcohol use? ___ If so, ______ <5/wk ______ >5/wk

Do you participate in any sports? __________ If so, which ones? ____________________

Occupation? ____________________ Employer: ____________________

Circle all that apply: use of cane walker crutches? Number of steps in your home? ______

☐ Female ☐ Male Height: _____ Weight: _____ BP: _____ Pulse: _____ Respiration: ______

C.Chandra, M.D. __________ R.Coddington, M.D. __________ M.Freeman, M.D. __________

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