

**SANDHILL ORTHOPAEDIC & SPORTSMEDICINE, L.L.C.**  
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**HISTORY & PHYSICAL**

DATE: \_\_\_\_\_

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_  
Height \_\_\_\_\_ Weight \_\_\_\_\_ Pulse \_\_\_\_\_ BP \_\_\_\_\_ Temperature \_\_\_\_\_  
Referred by \_\_\_\_\_ Personal Physician \_\_\_\_\_  
Occupation \_\_\_\_\_ Date of injury \_\_\_\_\_  
Complaint: \_\_\_\_\_

Obtain records from: \_\_\_\_\_

**Surgical History:** \_\_\_\_\_

**Medical History:** \_\_\_\_\_

**Medications:** \_\_\_\_\_

**Allergies:** \_\_\_\_\_

Could you be pregnant? \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ LMP \_\_\_\_\_

**Family & Social History:** Is there a family history of any health problems such as:

Yes

Explain

Cardiac	_____	_____
Diabetes	_____	_____
Blood Pressure	_____	_____
Stroke	_____	_____
Arthritis/similar disorder	_____	_____
Hx requiring bracing or surgery	_____	_____
Alcohol	_____	_____
Smoke	_____	_____
Cancer	_____	_____

**Review of systems:**

Are you now, or have you ever been treated for any of the following:

<u>CNS:</u>	Yes	Explain
Headache, blurred vision	_____	_____
Loss of consciousness	_____	_____
Stroke	_____	_____
Dysphagia	_____	_____
Problems w/prior intubation	_____	_____
Epilepsy/seizures	_____	_____
<u>Neck:</u>		
Thyroid disease	_____	_____
<u>Chest:</u>		
Cough	_____	_____
Shortness of breath	_____	_____
Blood in sputum	_____	_____
Tuberculosis	_____	_____
COPD	_____	_____
Asthma	_____	_____
<u>Cardiovascular:</u>		
Hypertension	_____	_____
Myocardial infarction	_____	_____
Chest pain	_____	_____
Elevated cholesterol	_____	_____
Arrhythmia	_____	_____
Blood clots (DVT)	_____	_____
Bleeding disorder	_____	_____
<u>Abdomen:</u>		
Jaundice/hepatitis/HIV	_____	_____
Diabetes	_____	_____
Peptic ucler disease	_____	_____
Kidney failure/stones	_____	_____
GI disease/abnormal stools	_____	_____
<u>GU:</u>		
Hernia	_____	_____
Blood in stool	_____	_____
UTI	_____	_____
<u>Affected Extremities:</u>		
Numbness, tingling, weakness	_____	_____
Swelling	_____	_____
Locking	_____	_____
Stiffness	_____	_____
Redness	_____	_____
Popping	_____	_____
Instability	_____	_____
Limping	_____	_____
Grinding	_____	_____
Deformity	_____	_____

Patient Signature \_\_\_\_\_