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**HEALTH HISTORY**

Date: \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Were you referred by a Physician? Yes  No

Who requested our services? \_\_\_\_\_ Family Physician \_\_\_\_\_

Reason for seeking medical attention \_\_\_\_\_ Right  Left  Both

Date of injury or duration of symptoms \_\_\_\_\_ Work related? Yes  No  Are you right or left handed? \_\_\_\_\_

Have you had any diagnostic studies for this condition, such as MRI, Bone Scan, etc.? Please List \_\_\_\_\_

Have you seen anyone else regarding this condition? Yes  No  If yes, list names and dates \_\_\_\_\_

Have you ever been diagnosed with any of the following medical conditions:

	Yes	No		Yes	No		Yes	No
Asthma	<input type="radio"/>	<input type="radio"/>	Rheumatoid Arthritis	<input type="radio"/>	<input type="radio"/>	Osteoarthritis	<input type="radio"/>	<input type="radio"/>
Kidney Disease	<input type="radio"/>	<input type="radio"/>	Anemia	<input type="radio"/>	<input type="radio"/>	Alcoholism	<input type="radio"/>	<input type="radio"/>
Lupus	<input type="radio"/>	<input type="radio"/>	Migraines	<input type="radio"/>	<input type="radio"/>	Sickle Cell Disease	<input type="radio"/>	<input type="radio"/>
Bleeding Tendencies	<input type="radio"/>	<input type="radio"/>	Cancer	<input type="radio"/>	<input type="radio"/>	Colitis	<input type="radio"/>	<input type="radio"/>
Heart Disease	<input type="radio"/>	<input type="radio"/>	Diabetes	<input type="radio"/>	<input type="radio"/>	Stroke	<input type="radio"/>	<input type="radio"/>
Epilepsy	<input type="radio"/>	<input type="radio"/>	Goiter	<input type="radio"/>	<input type="radio"/>	Stomach Ulcers	<input type="radio"/>	<input type="radio"/>
High Blood Pressure	<input type="radio"/>	<input type="radio"/>	Lung Disease	<input type="radio"/>	<input type="radio"/>	Depression/Anxiety	<input type="radio"/>	<input type="radio"/>
Polio	<input type="radio"/>	<input type="radio"/>	Nervous System Disorder	<input type="radio"/>	<input type="radio"/>	Pelvic Radiation	<input type="radio"/>	<input type="radio"/>
Hepatitis	<input type="radio"/>	<input type="radio"/>	Tuberculosis	<input type="radio"/>	<input type="radio"/>	COPD	<input type="radio"/>	<input type="radio"/>
						(Chronic Obstructive Pulmonary Disease)		

Other Medical Conditions: \_\_\_\_\_

Are there law suits pending on your orthopaedic conditions? \_\_\_\_\_

Please list any orthopaedic surgeries and dates:

Please list any other surgeries and dates:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please list all current medications and dosages:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Are you allergic to: (check if you are)

- Latex  Penicillin  Cephalosporin  Mycins  Sulfa  Tetanus  Iodine  
 Dyes  Aspirin  Codeine  Morphine  Adhesive Tape  Arthritis Medicine

Foods (please list) \_\_\_\_\_

Others: \_\_\_\_\_

Please explain allergic reaction: \_\_\_\_\_

Do you currently use tobacco:  Cigarettes  Pipe  Smokeless  Amount per day: \_\_\_\_\_ Quit when? \_\_\_\_\_

Do you drink alcohol:  Beer  Liquor  Wine  Amount per day: \_\_\_\_\_ or per week: \_\_\_\_\_

What is your current occupation? \_\_\_\_\_

Has anyone in your family had:

- High Blood Pressure  Heart Disease  Cancer\*  Diabetes  Bleeding Problems  Lung Disease

\*If yes, what type of cancer?

Have you recently had any of the following problems or symptoms:

	Yes	No		Yes	No		Yes	No
Chest Pain	<input type="radio"/>	<input type="radio"/>	Irregular Heart Beat	<input type="radio"/>	<input type="radio"/>	Fainting Spells	<input type="radio"/>	<input type="radio"/>
Breathing Difficulties	<input type="radio"/>	<input type="radio"/>	Cough	<input type="radio"/>	<input type="radio"/>	Cough with Blood	<input type="radio"/>	<input type="radio"/>
Numbness or Tingling	<input type="radio"/>	<input type="radio"/>	Dizziness	<input type="radio"/>	<input type="radio"/>	Headaches or Migraines	<input type="radio"/>	<input type="radio"/>
Vision Changes	<input type="radio"/>	<input type="radio"/>	Fever or Chills	<input type="radio"/>	<input type="radio"/>	Unexpected Weight Loss	<input type="radio"/>	<input type="radio"/>
Abdominal Pain	<input type="radio"/>	<input type="radio"/>	Nausea or Vomiting	<input type="radio"/>	<input type="radio"/>	Diarrhea	<input type="radio"/>	<input type="radio"/>
Bloody or Black Tarry Stools	<input type="radio"/>	<input type="radio"/>	Loss of Control of Bowels	<input type="radio"/>	<input type="radio"/>	Difficulty Starting Urine	<input type="radio"/>	<input type="radio"/>
Pain or Burning on Urination	<input type="radio"/>	<input type="radio"/>	Blood in Urine	<input type="radio"/>	<input type="radio"/>	Loss of Control of Bladder	<input type="radio"/>	<input type="radio"/>

Patient Signature \_\_\_\_\_ Physician's Signature \_\_\_\_\_ Date: \_\_\_\_\_

(I have reviewed this information with the patient)

Ht. \_\_\_\_\_ Wt. \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ / \_\_\_\_\_ Pulse \_\_\_\_\_