Date:__________ **PATIENT HISTORY** **Thomas Youm, MD**

RYC Orthopaedics, PC

Name________________________________ Employer________________________________
Address______________________________ Address_________________________________
______________________________________ ____
Phone(H)__________________ DOB______ SS#_____________________________________
(W)__________________Age_______ Referring Doctor:________________--______
Insurance____________________________ Address_________________________________
Policy_______________________________ Phone__________________________________
Policy Holder:_________________________ Other Referral:___________________________

Initial Visit Date______________________ Occupation______________________________
Age__________ Height____________ Weight_________ *Handed:* R L
Eyes_______ Hair_______ *Sex:* M F *Race:* W______B______Asian_____Hisp_____

Chief Complaint *(main problem)* 1.____
Other complaints: *2.*________________________________*3.*______________________________
Neck Arms *R L* Back Hip *R L* Knees *R L* Ankles *R L* Feet *R L*

History Present Illness *(what happened?)* ***Date of Injury:*___________________________**
____
____
____

Did the problem result from an injury or accident?________If so, explain___________________
____
Location of pain________________________Does it travel to other areas?__________________
For how long?_________________________________ Pain on a scale of 1-10________________
Is the pain: Constant___ Sharp___ Dull___ At Night___ Other__________________________
Symptoms: Numbness/pins & needles___ Locking__ Giving way__ Swelling__ Other______
What makes the pain *better*?________________________*worse*?__________________________
What treatments have you tried? Nothing__ Medications(specify)__________________________
PT______ Injections(specify)____________________Other_____________________________
Improvement with treatment? Which? ____
Studies? *Xrays* ____________*MRI*____________ *CT Scan*_____ *EMG*______ *Other*______
(When? Results?)____
Notes:

Review of Systems: Have you had any of the following recently?

Fever or Chills______ Blurred Vision_____ Shortness of Breath______ Sore Throat______

Chest Pain_________ Nausea/Vomiting_____ Painful Urination_________ Rashes__________

Easy Bleeding/Bruising_____ Seizures______ Headaches________ Hallucinations ________

If so, explain:____

Allergies__________________***Drug Allergies***_____________***Tolerate NSAIDs***? ___________

Social Hx: Tobacco___ Alcohol___ Drugs___ ***Pregnant***: Y N ***Marital Status***: S M D W

Family History: DIABETES HEART DISEASE CANCER HYPERTENSION STROKE

If parent(s) deceased, underlying condition? Mother______________ Father______________

Medical Hx: HEART LUNGS STOMACH LIVER KIDNEY BLADDER DIABETES HTN

Explain:____

____

Prior Surgeries____

____

____

Medications____

____

____

Are you taking blood thinners: COUMADIN ASPIRIN PLAVIX ___________________

*Signature of Patient*__________________________________ *Date*_____________________

Physician Notes:

*Signature of Doctor*__________________________________ *Date*_____________________