NASHVILLE
HIP INSTITUTE
PRESERVATION, RECONSTRUCTION
& SPORTS MEDICINE

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PATIENT HEALTH HISTORY

Patient Name: _____ Preferred Name: _____

Sex: ☐ Male ☐ Female Date of Birth:_____Height:_____Weight:_____

Name of Primary Care Provider:_____Phone:_____

Pharmacy Preference: _____Phone:_____

Reason for appointment: _____

Please list any medications you are currently taking (prescription and over the counter):

Name	Dosage	Frequency	Route (oral, injection, etc.)

Are you allergic to any medications? ☐ No ☐ Yes

Drug Name	Reaction

Can you take anti-inflammatory medications? ☐ No ☐ Yes
Do you take any anti-inflammatories, blood thinners, aspirin products or vitamins containing Vitamin E? ☐ No ☐ Yes
Please list: _____

Past surgeries and dates: _____

_____

Have you ever had MRSA (staph infection)? ☐ No ☐ Yes
If so, when and where? _____

Hand dominance: ☐ Right ☐ Left Current occupation: _____

Female patients: Do you think you are pregnant? ☐ No ☐ Yes
Date of last menstrual period: _____

Name: _____

PAST MEDICAL HISTORY

Check if you currently suffer or have previously suffered from:

☐ Osteoporosis ☐ Arthritis ☐ Thyroid: ☐ Hyper ☐ Hypo

☐ Deep vein thrombosis ☐ Pulmonary embolism ☐ Alzheimer's/ Dementia

☐ High blood pressure ☐ Heart disease or heart attack ☐ Stroke

☐ Kidney disease ☐ Liver disease ☐ Seizures ☐ Anxiety ☐ Loose joints

☐ Diabetes ☐ Asthma ☐ Depression ☐ Gout ☐ Reflux disease (GERD)

☐ Gastric ulcers ☐ Gastritis ☐ COPD ☐ Tuberculosis ☐ Elevated cholesterol

☐ Polio ☐ Rheumatic fever ☐ Ulcerative colitis

Cancer (what kind and when: _____

Other: _____

_____

Please circle family history conditions:

☐ Blood Clots ☐ Diabetes ☐ Hypertension ☐ Rheumatoid Arthritis ☐ Anesthesia problems

☐ Cancer ☐ Heart Disease ☐ Osteoporosis ☐ Stroke ☐ Seizures

SOCIAL HISTORY

Tobacco Use: ☐ Never smoke ☐ Former smoker ☐ Everyday ☐ Some days

Alcohol Use (drinks per day): ☐ 0 ☐ 1 ☐ 2-3 ☐ 4-5 ☐ 6 or more

Recreational Drug Use? ☐ No ☐ Yes Frequency: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Anything else we may need to know: _____

_____

Name: _____

HISTORY OF YOUR HIP PAIN

Is the pain **CHRONIC**? ☐ No ☐ Yes If **YES**, how long?_____

Is the pain **NEW** as a result of a specific injury? ☐ No ☐ Yes

If **YES**, date of injury/accident: / /

Was it a ☐ Work injury or ☐ Motor Vehicle Accident? ☐ No

Briefly describe how the initial pain began and how it limits your current level of activity:

_____

_____

Have you seen another physician for this injury? ☐ No ☐ Yes

If **YES**, who? _____

What treatments have you tried? ☐ Nothing ☐ Physical therapy ☐ Exercise ☐ Acupuncture ☐ Chiropractic ☐ Bursa injections ☐ Joint injections ☐ Ice ☐ Decreased activity/rest ☐ Medications: _____

When was the first time you went to a doctor about it? _____

Who was the doctor? _____

What Medications have you taken for this problem?

Prescription: _____

Over-the-counter: _____

How long have you taken these medications? _____

Have you ever been told that you cannot take anti-inflammatories (NSAIDs)?

(Advil, Motrin, Celebrex, etc.)? ☐ No ☐ Yes

If **YES**, please explain: _____

Are you using any assistive devices? (for example: cane, crutches, etc.) ☐ No ☐ Yes

If **YES**, what kind? _____

Have you modified your activities because of your hip pain and/or a diagnosis of FAI including restriction of your athletic pursuits and/or avoidance of symptomatic movements? ☐ No ☐ Yes

If **YES**, how? _____

_____

_____

Patient signature: _____ Date: _____