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

NO-FAULT

RYC Orthopaedics, PC

Name_____ Employer_____
Address_____ Address_____
_____ _____
Phone(H)_____ DOB_____ SS#_____
(W)_____Age_____ Requesting Doctor:_____
Insurance_____ Address_____
Policy#_____ Phone_____
File#_____ Other Referral:_____
Policy Holder:_____ _____

Initial Visit Date_____ Occupation_____
Age_____ Height_____ Weight_____ *Handed:* R L
Eyes_____ Hair_____ *Sex:* M F *Race:* W_____B_____Asian_____Hisp_____

History Present Illness *(what happened?)* ***Date of Accident:_____***

_____
_____
_____

Location of accident:_____
Driver: YES NO Passenger: FRONT SEAT BACK SEAT PEDESTRIAN
Car was struck in: FRONT BACK DRIVER SIDE PASSENGER SIDE
By: CAR TRUNK VAN BUS OTHER_____
Was taken to: Hospital Name_____When_____
Xrays taken: YES NO AREA:_____
By: AMBULANCE CAR WALK
Hospitalized: YES NO How long_____ ER Only_____
Lost Consciousness: YES NO How Long_____

Injuries Suffered:

Head: Headaches Dizziness Nausea Vomiting Blurred Vision
*Neck*_____ *Upper Back*_____ *Lower Back*_____ *Chest*_____
Upper Extremities: Collar Bone R L; Shoulder R L; Upper Arm R L
Elbow R L; Forearm R L; Wrist R L; Hand R L
Lower Extremities:
Hip R L; Thigh R L; Knee R L; Leg R L; Ankle R L; Foot R L

What are your complaints now: _____

_____

_____

What other doctors have you seen:_____

_____

Any other accident or operation (even if not related) YES NO

What and when:_____

_____

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?)_____

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

Fever or Chills_____ Blurred Vision_____ Shortness of Breath_____ Sore Throat_____

Chest Pain_____ Nausea_____ Painful Urination_____ Rashes_____ Headaches_____

If so, explain:_____

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*_____

*Signature of Doctor*_____ *Date*_____