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*____________________