Orthopedic Clinic

Medical History Form

Name: _____ Age: _____ Birthdate: _____

Height: _____ Weight:

Primary Care Physician, location and phone number: _____

_____

Date of injury or onset of symptoms: _____

What body part(s) are we seeing you for today? Please specifiy right, left, or both. _____

_____

Is this injury due to an accident? ◯ Yes ◯ No Date: _____

How/where did the injury occur? (Check one)

- ◯ Home, recreational, sports, etc.
- ◯ Motor Vehicle Accident or other "non-work" related liability
- ◯ Work

Please describe how and where the condition we are seeing you for occurred (be specific).

_____

_____

_____

_____

Have you received any previous treatment for the condition we are seeing you for today? YES / NO

If yes, please explain. _____

_____

Please list any past surgeries and approximate date:

_____

_____

Do you have any difficulties with anesthesia? ◯ Yes ◯ No

If yes, please explain. _____

_____

Are you allergic to any medication(s)? ◯ Yes ◯ No

If yes, please list all medications and reactions.

_____

_____

Please list all medications you are currently taking, including over the counter medications, vitamins, supplements and herbal remedies. Please list dosage and frequency.

SOCIAL HISTORY

Do you smoke or use smokeless tobacco? ◯ Yes ◯ No

If yes, how long _____ how much _____

If you smoked or used smokeless tobacco in the past, how long since you quit? _____

Do you consume alcohol? ◯ Yes ◯ No

If yes, please estimate comsumption (circle one)

Occasionally	Moderately	Heavy
(rarely)	(1-2 daily)	(5 or more daily or over an extended period of time)

FAMILY HISTORY: Please indicate the health status of your immediate family members.

	Alive & well	Serious disease?	Cause of death?
Mother			
Father			
Siblings			

PERSONAL HEALTH

Have you been hospitalized within the past 5 years for ANY condition? ◯ Yes ◯ No

If yes, please list dates and condition: _____

Do you have any other health problems not listed? ◯ Yes ◯ No

FEMALES ONLY

Are you pregnant? ◯ Yes ◯ No If yes, when are you due? _____

Have you gone through menopause? ◯ Yes ◯ No When? _____

PERSONAL HEALTH (cont.): Please check Y**es** or N**o** for the following. Explain **Yes** answers.

◯ Yes ◯ No Visual problems: ◯ Glaucoma ◯ Glasses ◯ Contacts ◯ Other_____
◯ Yes ◯ No Hearing difficulties _____
◯ Yes ◯ No Frequent ear infections _____
◯ Yes ◯ No Sore or other throat infections _____
◯ Yes ◯ No Nasal discharge or congestion _____
◯ Yes ◯ No Chronic sinus infection/sinusitis _____
◯ Yes ◯ No Frequent nosebleeds _____
◯ Yes ◯ No Sleep apnea _____
◯ Yes ◯ No Asthma _____
◯ Yes ◯ No Chronic cough. If yes, productive cough with secretions? ◯ Yes ◯ No
◯ Yes ◯ No Emphysema or other diseases of the lung _____
◯ Yes ◯ No High blood pressure _____
◯ Yes ◯ No Heart arrhythmia or palpitations _____
◯ Yes ◯ No Other cardiac disease/problems _____
◯ Yes ◯ No Gastrointestinal problems _____
◯ Yes ◯ No Urinary tract infection(s) _____
◯ Yes ◯ No Kidney infections _____
◯ Yes ◯ No Have you had a concussion/head injury? If yes, were you hospitalized? YES / NO
◯ Yes ◯ No Have you ever had a seizure? _____
◯ Yes ◯ No Other neurological problems _____
◯ Yes ◯ No Rashes of infections on your skin _____
◯ Yes ◯ No Diabetes. If yes, are you insulin dependent? ◯ Yes ◯ No
◯ Yes ◯ No Thyroid disease _____
◯ Yes ◯ No Hormonal or endocrine problems _____
◯ Yes ◯ No Have you ever had hepatitis? If yes, when? _____
◯ Yes ◯ No Any problems with excessive bleeding or bruising? _____
◯ Yes ◯ No Swelling or color changes in extremities? ◯ Yes ◯ No
If yes, indicate where ◯ hands/fingers ◯ legs ◯ feet/toes ◯ Other _____

I, the undersigned, have read and understand the questions asked on this form. I also confirm that the above medical history provided on this form is true and complete to the best of my knowledge.

_____ _____
Patient signature (or legal guardian) Date