Medical History Form

Please fill out completely due to this being a part of your permanent medical record.

Name:________________________________ Date:_____________ SSN:_______-_____-_________

Please Circle: Mr. Mrs. Ms. Dr. Rev. Sr. Pregnant: Y / N Age:______ Birthdate:_____________

Right / Left Handed:_______ Date of Accident/Injury:_______ Name of Spouse:_________________

Telephone Numbers: Home (   )________-__________ Work (   )________-__________

Drug *Allergies*:______________________________ Height:______ Weight:______

Chief Complaint:____

Please describe the recent events of this current orthopedic problem. Answer how long it has been a problem, what makes it worse, and what makes it better:

____

____

Please list all Current Medications:

1.________________________________ 4.________________________________
2.________________________________ 5.________________________________
3.________________________________ 6.________________________________

Past Surgeries: Please list in chronological order from oldest to newest and year of surgery.

1.________________________________ 3.________________________________
2.________________________________ 4.________________________________

List any diagnostic studies you have had for this condition along with date and place the study was performed. (MRI, CAT Scan, X-rays, EMG, NCV etc.):

1.________________________________ 3.________________________________
2.________________________________ 4.________________________________

Family Medical History: List medical illnesses affecting your immediate family, i.e., parents/siblings.

Disease   Family Member   Disease   Family Member

1.________________________________ 3.________________________________
2.________________________________ 4.________________________________

Social History: Check and fill in the blanks.

_____Married _____Single _____Divorced _____Live alone #_____Children #_____Pets
_____Alcohol _____Occasional _____Moderate _____Heavy _____History of Abuse
_____Tobacco _____Years used _____Packs per day _____Recreational drugs _____Yrs used

General History: Please check if any apply

General

____1. Weight change
____2. Fever or chills
____3. Night sweats
____4. Urinary frequency
____5. Bleeding
____6. Lumps or masses
____7. Dizziness or fainting
____8. Itching or rash
____9. Diabetes mellitus
____10.Thyroid problem
____11.Cancer

Ear-Nose-Throat-Eye
____1. Visual change
____2. Hearing change
____3. Tinnitus
____4. Dentures
____5. Bleeding gums
____6. Hoarseness

Gastrointestinal

____1.Dysphagia (difficulty swallowing)
____2. Nausea & vomiting
____3. Jaundice
____4. Hepatitis

Cardiovascular
____1. Heart dx/pain
____2. Hypertension
____3. Mitral valve prolapse
____4. Thrombophlebitis

Respiratory
____1. Cough/sputum
____2. Rheumatic fever
____3. Tuberculosis
____4. Pleurisy/pneumonia
____5. Shortness of breath
____6. Asthma

Genitourinary

____1. Urinary tract. infections
____2. Incontinence
____3. Venereal diseases
____4. Menopause

Neurologic
____1. Seizures
____2. Paralysis
____3. Numbness
____4. Weakness

Musculoskeletal
____1. Backache
____2. Joint pain
____3. Joint swelling

Breast
____1. Lumps, pain, discharge

Other medical conditions not listed above:
1. ____
2. ____

Description of current employment/Occupation:

____

Is injury work related? ____Yes ____No

Who referred you to our office?

____

Name of Primary Care Physician:

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