



Medical History Form

Patient Name: _____ Appointment Date: _____ with Dr. _____

Age: _____ Sex: F M Height: _____ Weight: _____ Dominant hand: R L

Did you bring X-rays? Y N Latex Allergy? Y N Metal Allergy? Y N

Who is your primary care physician? (name): _____ MD PA

What is the reason for this visit? Pain Numbness Weakness Swelling Stiffness Other _____

What body part is involved? (Please mark the table below)

Shoulder <input type="checkbox"/> R <input type="checkbox"/> L	Elbow <input type="checkbox"/> R <input type="checkbox"/> L	Wrist <input type="checkbox"/> R <input type="checkbox"/> L	Hand <input type="checkbox"/> R <input type="checkbox"/> L	Hip <input type="checkbox"/> R <input type="checkbox"/> L	Knee <input type="checkbox"/> R <input type="checkbox"/> L	Ankle <input type="checkbox"/> R <input type="checkbox"/> L	Foot <input type="checkbox"/> R <input type="checkbox"/> L	Neck <input type="checkbox"/> R <input type="checkbox"/> L	Back <input type="checkbox"/> R <input type="checkbox"/> L
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How long ago did it start? _____ Days _____ Weeks _____ Months _____ Years.

Have you ever had a problem like this before? Y N

In this section, check the **ONE BOX** which best describes *how your problem started*. Then answer the questions below the box you checked.

NO INJURY (or onset was: Gradual *or* Sudden)

Please indicate *why* do you think it started? _____

INJURY (Accident Sport (NOT Auto or Work))

Date: _____ Please specify where and how it happened. _____

INJURY AT WORK Date: _____

From a: lift twist fall bend pull reach

WORK RELATED (BUT NO INJURY)

Date: _____ How did your job cause the problem? _____

AUTO ACCIDENT Date: _____ How was your car hit? _____

On a scale of 0-10 (10 is the worst) how severe is your pain? (circle) 0 1 2 3 4 5 6 7 8 9 10

What is the quality of the pain? Sharp Dull Stabbing Throbbing Aching Burning

The pain is: Constant Comes and goes (intermittent).

Does your pain wake you from your sleep? Y N

Do you have: Swelling Bruises Numbness Tingling Weakness

Loss of control of bowel or bladder Locking/Catching Giving way

Since my problem started, it is: Getting better Getting worse Unchanged

What makes your symptoms worse? Standing Walking Lifting Exercise Twisting

Lying in bed Bending Squatting Kneeling Stairs Sitting Coughing Sneezing

Which make your symptoms better? Rest Elevation Ice Heat Other: _____

Have you had any of these treatments? Injection: Y N Brace: Y N Physical Therapy: Y N
Cane/Crutch: Y N

Were you seen in the E.R. for this problem? N Y Which E.R.? _____ Date: _____

Are you here today as a result of an E.R. Visit? N Y Who saw you in E.R.? _____ MD

What test/scans have you had for this problem?

X-Rays MRI CAT Scan Bone Scan Nerve Test (EMG/NCV) Where? _____

Have you already had surgery for a problem in this same area either recently or in the past? Y N

Please list below:

Procedure #1 _____ Surgeon _____ City _____ Date _____

Procedure #2 _____ Surgeon _____ City _____ Date _____

Current work status? Regular Light Duty - (how long? _____) Not working due to this problem

Disabled Retired Student

When is the last date you worked your regular job? _____

Are you currently receiving or plan to apply for:

Disability: Y N

Worker's Comp: Y N

Unemployment: Y N

REVIEW OF SYSTEMS

Have you had a prior problem with this same Orthopedic condition in the past? N Y (explain below)

Do your other joints have: morning stiffness lasting over 30 minutes joint pain or swelling Back Pain Gout

Rheumatoid arthritis Osteoporosis prior fracture (which bone) _____ None of these

Have you had any of these symptoms? If no, mark None.

		<i>NONE</i>	<i>YEAR</i>	<i>Details/Comments</i>
<i>GI</i>	<input type="checkbox"/> Heartburn, ulcers <input type="checkbox"/> Nausea, Vomiting <input type="checkbox"/> Blood in Stool <input type="checkbox"/> Hepatitis <input type="checkbox"/> Liver disease	<input type="checkbox"/>	_____	_____
<i>ENDO</i>	<input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Heat or Cold Intolerance	<input type="checkbox"/>	_____	_____
<i>CON</i>	<input type="checkbox"/> Weight Loss <input type="checkbox"/> Loss of Appetite	<input type="checkbox"/>	_____	_____
<i>EYE</i>	<input type="checkbox"/> Blurred Vision <input type="checkbox"/> Double Vision <input type="checkbox"/> Vision Loss	<input type="checkbox"/>	_____	_____
<i>ENT</i>	<input type="checkbox"/> Hearing Loss <input type="checkbox"/> Hoarseness <input type="checkbox"/> Trouble Swallowing	<input type="checkbox"/>	_____	_____
<i>CV</i>	<input type="checkbox"/> Chest Pain <input type="checkbox"/> Palpitations	<input type="checkbox"/>	_____	_____
<i>RS</i>	<input type="checkbox"/> Chronic Cough <input type="checkbox"/> Shortness of Breath	<input type="checkbox"/>	_____	_____
<i>GU</i>	<input type="checkbox"/> Painful Urination <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Kidney Problems	<input type="checkbox"/>	_____	_____
<i>SK</i>	<input type="checkbox"/> Frequent Rashes <input type="checkbox"/> Skin Ulcers <input type="checkbox"/> Lumps <input type="checkbox"/> Psoriasis	<input type="checkbox"/>	_____	_____
<i>NEU</i>	<input type="checkbox"/> Headaches <input type="checkbox"/> Dizziness <input type="checkbox"/> Seizures	<input type="checkbox"/>	_____	_____
<i>PSY</i>	<input type="checkbox"/> Depression <input type="checkbox"/> Drug/Alcohol Addiction <input type="checkbox"/> Sleep disorder	<input type="checkbox"/>	_____	_____
<i>HEM</i>	<input type="checkbox"/> Easy Bleeding <input type="checkbox"/> Easy Bruising <input type="checkbox"/> Anemia	<input type="checkbox"/>	_____	_____

ARE YOU HIV POSITIVE: N Y

PAST MEDICAL HISTORY:

Are you Diabetic? N Y If Yes, treatment: Insulin Oral Meds Diet None

Are you taking, or have you ever taken blood thinners? N Y If yes, which one? _____

Past Surgical History: What operations have you had and when? Please list: _____

Have you or a family member ever had a reaction to anesthesia? N Y EXPLAIN: _____

Past Hospitalizations: (*Not for Surgery*): _____

None

List any medical conditions you currently have or have been treated for in the past:

What medications are you taking now? _____

ALLERGIC TO ANY MEDICATIONS? Y N *if *yes* please list and describe reaction: _____

FAMILY HISTORY: Have any *direct* relatives had any of the following disorders? If so, which relative?

Diabetes _____ High Blood Pressure _____ Rheumatoid Arthritis _____ None

Do any direct relatives have the same condition you are being seen for today? Y N

SOCIAL HISTORY:

Do you use tobacco? N Y If yes, packs per day _____ Patient informed of Smoking Risk? Y

Alcohol use? N Y If yes, how often? Daily Other _____/week Marital History: M S D W

How many people live with you? _____ Occupation: _____ Employer: _____

Student Do you plan to be working 6 months from now? Y N

PLEASE SIGN: *The information on this form is accurate to the best of my knowledge.*

Signature

Date