Office Use Only: Account #_____ Date: _____
Height:_____ Weight:_____ BP:_____ Pulse:_____ M.A. Initials:_____

Medical History Form (Please Print)

Patient Name: _____Appointment Date:_____with Dr._____
DOB:_____ Age: _____ Sex: ☐F ☐M Dominant Hand: ☐R ☐L Did you bring x-rays? ☐Y ☐N
Primary Physician: Name_____ Street_____ City_____
State_____Zip_____Phone:_____ Referred by: Name: _____
Street _____ City_____ State_____ Zip_____Phone_____
CHIEF COMPLAINT: What is the reason for this visit? ☐Pain ☐Numbness ☐Weakness ☐Swelling ☐Stiffness ☐ Other _____
What body part is involved? Please mark the table below or complete for other: _____

Shoulder	Elbow	Wrist	Hand	Hip	Knee	Ankle	Foot	Neck	Back
☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L	☐R ☐L

HISTORY OF PRESENT ILLNESS: **Date of Onset**:_____ Or, how long ago did it start? ___Days ___Weeks ___Months ___Years Have you 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 regarding the box you checked (see COMMENTS).
☐ 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. What sport?_____ School?_____
☐ 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?
COMMENTS:_____
_____

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 ☐Fever ☐Chills ☐Sweats ☐Chest pain ☐Shortness of breath
Since your 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? Medications: ☐ Y ☐ N Which ones?_____
Injection: ☐Y ☐N Brace: ☐Y ☐N Physical Therapy: ☐Y ☐N Cane/Crutch: ☐Y ☐N
Were you seen in the E.R. for this problem: ☐Y ☐N Which E.R.?_____ Date:_____
Are you here today as a result of an E.R. visit? ☐Y ☐N Who saw you in E.R.?_____ ☐MD ☐PA
What tests have you had for this problem? ☐X-rays ☐MRI ☐CAT Scan ☐Bone Scan ☐Nerve Test (EMG/NCV)
Where? _____ Date(s):_____
For other problems: Body Part(s): _____
Where? _____Date(s):_____
Have you already had surgery for a problem in this same area either recently or in the past? ☐N ☐Y
List: Procedure #1_____Surgeon_____City_____Date_____
Procedure #2_____Surgeon_____City_____Date_____
Occupation: _____
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 / plan to apply for: Disability: ☐Y ☐N Workers' Comp: ☐Y ☐N Unemployment: ☐Y ☐N
MEDICAL HISTORY: **ALLERGIC TO ANY MEDICATIONS?** ☐Y ☐N If yes, please list and describe reaction:_____
_____
_____**Latex Allergy**? ☐Y ☐N

Please turn over to complete other side.

MEDICAL HISTORY (Continued): **PATIENT NAME:**_____

LIST ALL MEDICATIONS YOU ARE TAKING NOW:_____

_____

_____

_____

Are you diabetic? ☐ N ☐ Y If yes, treatment: ☐ Insulin ☐ Oral medications ☐ Diet ☐ None

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

Have you ever had: ☐ Heart attack (year_____) ☐ High blood pressure ☐ Blood clots (year_____) ☐ Stroke

☐ Heart failure ☐ Ankle swelling ☐ Kidney failure ☐ Cancer (location_____)

☐ Stomachache while taking anti-inflammatory (includes Advil/Aleve). What anti-inflammatory have you already had a problem with?_____

☐ OTHER: _____

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

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:_____

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

Have you had a prior problem with this same Orthopaedic 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

☐ rheumatoid arthritis ☐ osteoporosis ☐ prior fracture (which bone) _____ ☐ None of these

REVIEW OF SYSTEMS:

Have you had any of these symptoms? If no, mark None.				None	Details / Other
1) GI	☐ Heartburn, ulcers	☐ Nausea, vomiting	☐ Blood in stool	☐	_____
	☐ Hepatitis	☐ Liver disease			_____
2) ENDO	☐ Thyroid disease	☐ Heat or cold intolerance		☐	_____
3) CON	☐ Weight loss	☐ Loss of appetite		☐	_____
4) EYE	☐ Blurred vision	☐ Double vision	☐ Vision loss	☐	_____
5) ENT	☐ Hearing loss	☐ Hoarseness	☐ Trouble swallowing	☐	_____
6) CV	☐ Chest pain	☐ Palpitations		☐	_____
7) RS	☐ Chronic cough	☐ Shortness of breath		☐	_____
8) GU	☐ Painful urination	☐ Blood in urine	☐ Kidney problems	☐	_____
9) SK	☐ Frequent rashes	☐ Skin ulcers ☐ Lumps	☐ Psoriasis	☐	_____
10) NEU	☐ Headaches	☐ Dizziness	☐ Seizures	☐	_____
11) PSY	☐ Depression	☐ Drugs/Alcohol Addiction	☐ Sleep disorder	☐	_____
12) HEM	☐ Easy bleeding	☐ Easy bruising	☐ Anemia	☐	_____
13) ARE YOU HIV POSITIVE:	☐ N ☐ Y				

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

Signature_____ Date_____

Office Use Only: Completed _____ Date_____

Review #1 by _____M.D. Date_____ Review #2 by_____M.D. Date_____