orthopedic ONE

Medical History Form

Patient Name: _____ Today's Date: _____

Social Security Number: _____ Date of Birth: _____ Age: _____

Height: _____ ft. _____ in. Weight: _____ lbs. Primary Care Physician: _____

Race (Please circle):
White | Black/African American | American Indian/Alaska Native | Asian | Native Hawaiian/other Pacific Islander | Other

Have you seen a cardiologist? ❑ Yes ❑ No If so, please list physician's name: _____

May we release information to your primary care physician? ❑ Yes ❑ No Consult requested by: _____

Reason for today's visit: _____

Was this the result of an accident? ❑ Yes ❑ No If yes, date of accident and please describe. Date: _____

_____

Where did the injury occur? ❑ Work ❑ Auto ❑ Home ❑ Other _____

Have you been previously seen for this condition? ❑ Yes ❑ No If so, please describe: _____

_____

Date symptoms began: _____

CURRENT MEDICATIONS *(Please include all prescription and over-the-counter medications):*

Name / Dose / How Often		Name / Dose / How Often	
1.	_____	7.	_____
2.	_____	8.	_____
3.	_____	9.	_____
4.	_____	10.	_____
5.	_____	11.	_____
6.	_____	12.	_____

Allergies? ❑ Yes ❑ No List them: _____

Do you have any metal allergies (e.g. nickel, etc.)? ❑ Yes ❑ No List them: _____

Do you have a latex allergy? ❑ Yes ❑ No Do you have a poultry allergy? ❑ Yes ❑ No

PERSONAL AND SOCIAL HISTORY

Do you use tobacco? ❑ Yes ❑ No If so, what type and how much? _____

Do you drink alcohol? ❑ Yes ❑ No If so, how much and how frequently? _____

Do you regularly participate in sports or physical activity? ❑ Yes ❑ No If so, how much and how frequently? _____

_____

FOR INTERNAL USE ONLY:

Physician's Signature: _____ Date: _____

PLEASE COMPLETE OTHER SIDE

Medical History Form

MEDICAL AND SURGICAL HISTORY Previous Surgeries *(please list most recent first):*

Surgery	Year	Surgery	Year
1.		4.	
2.		5.	
3.		6.	

Have you had general anesthesia? ❑ Yes ❑ No Any problems? _____

PERSONAL MEDICAL HISTORY

❑ Y ❑ N **Anxiety**
❑ Y ❑ N **Asthma**
❑ Y ❑ N **Atrial fibrillation**
❑ Y ❑ N **Bleeding disorder**
❑ Y ❑ N **Cancer** (Type: _____)
❑ Y ❑ N **Claustrophobia**
❑ Y ❑ N **Congestive heart failure**
❑ Y ❑ N **COPD**
❑ Y ❑ N **Depression**
❑ Y ❑ N **Diabetes**
❑ Y ❑ N **Drug/alcohol dependency**
❑ Y ❑ N **DVT (blood clots)**
❑ Y ❑ N **Enlarged prostate**
❑ Y ❑ N **Epilepsy / Seizures**
❑ Y ❑ N **Fibromyalgia**
❑ Y ❑ N **GERD**
❑ Y ❑ N **Gout**
❑ Y ❑ N **Heart attack**
❑ Y ❑ N **Heart disease**
❑ Y ❑ N **Hepatitis** (Type: _____)
❑ Y ❑ N **High blood pressure**
❑ Y ❑ N **High cholesterol**
❑ Y ❑ N **HIV / AIDS**
❑ Y ❑ N **Hypothyroidism**
❑ Y ❑ N **Kidney disease**
❑ Y ❑ N **Liver disease**
❑ Y ❑ N **Morbid obesity**
❑ Y ❑ N **MRSA**
❑ Y ❑ N **Neuropathy**
❑ Y ❑ N **Osteoarthritis**
❑ Y ❑ N **Osteoporosis**
❑ Y ❑ N **Pneumonia**
❑ Y ❑ N **Psoriasis**
❑ Y ❑ N **Pulmonary embolism (PE)**
❑ Y ❑ N **Rheumatoid Arthritis**
❑ Y ❑ N **Scoliosis**
❑ Y ❑ N **STD** (Type: _____)
❑ Y ❑ N **Stomach ulcer**
❑ Y ❑ N **Stroke/TIA**
❑ Y ❑ N **Other:** _____

Do you suffer from sleep apnea? ❑ Y ❑ N If so, are you assisted by C-PAP? ❑ No ❑ Yes / Setting: _____
Have you had an influenza vaccine? ❑ Y ❑ N If so, date: _____
Have you had a pneumonia vaccine? ❑ Y ❑ N If so, date: _____
Do you have cardiac stents? ❑ Y ❑ N
Do you have a pacemaker? ❑ Y ❑ N If so, please specify: _____
Do you have a defibrillator? ❑ Y ❑ N If so, please specify: _____

FAMILY HISTORY *(Please check any that have occurred in any blood relatives):*

❑ Y ❑ N Cancer (Type _____) ❑ Y ❑ N Diabetes ❑ Y ❑ N Heart disease ❑ Y ❑ N Stroke

❑ Y ❑ N Bleeding tendencies ❑ Y ❑ N DVT (blood clots) ❑ Y ❑ N High blood pressure ❑ Y ❑ N Other: _____

REVIEW OF SYSTEMS Are you CURRENTLY experiencing any of these conditions / symptoms?

Constitutional
❑ Y ❑ N Fever
❑ Y ❑ N Chills
❑ Y ❑ N Weight Loss

Cardiovascular
❑ Y ❑ N Chest pain
❑ Y ❑ N Irregular beat

Gastrointestinal
❑ Y ❑ N Abdominal pain
❑ Y ❑ N Reflux
❑ Y ❑ N Difficulty swallowing

Skin
❑ Y ❑ N Unusual bruises
❑ Y ❑ N Rashes

Musculoskeletal
❑ Y ❑ N Joint swelling
❑ Y ❑ N Joint pain

Neurologic
❑ Y ❑ N Numbness / Tingling
❑ Y ❑ N Migraines
❑ Y ❑ N Weakness

Genitourinary
❑ Y ❑ N Incontinence

Hematologic
❑ Y ❑ N Excessive bleeding

Respiratory
❑ Y ❑ N Shortness of breath

Psychiatric
❑ Y ❑ N Mental illness

Other

_____
_____
_____
_____

If you checked any of the above, are you receiving treatment? ❑ Yes ❑ No Please specify: _____

Patient's Name (Please Print):_____

Patient's Signature: _____ Date: _____