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Orthopedic Surgeon & Sports Medicine

MEDICAL HISTORY FORM

Patient Name: _____ Date of Birth: _____

Age: _____ Sex: ○ M ○ F Height: _____ Weight: _____

Race: _____ Ethnicity: _____ Preferred Language: _____

Referring Physicians Name: _____

Part of the body being seen for today: ○ R ○ L _____

In this section, selct the option which best describes how your problem started.

○ NO INJURY Was the onset ○ Gradual ○ Sudden
Onset Date: _____

○ INJURY ○ Accident ○ Sport
Date of injury: _____

○ INJURY AT WORK Date of work injury: _____

○ Lift ○ Twist ○ Fall ○ Bend ○ Pull ○ Reach ○ Repetitive

○ AUTO ACCIDENT Date of auto accident: _____

Description of Injury / Accident

_____
_____
_____
_____
_____
_____
_____
_____

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

Were you seen in the E.R. for this problem? ○ Y ○ N if yes, Which E.R.? _____

What tests have you had for this problem? ○ X-rays ○ MRI ○ CAT Scan ○ Bone Scan ○ Nerve (EMG / NCV)

On a scale of 0-10 (10 is the worst) how severe is your pain?

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

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

The pain is ○ Constant ○ Intermittent (comes & goes)

Does the pain wake you from your sleep? ○ Y ○ N

I experience: ○ Swelling ○ Bruising ○ Numbness ○ Tingling ○ Weakness ○ Loss of control bowel or bladder

○ Locking / Catching ○ Giving way ○ Pain ○ Stiffness Other _____

Since my problem started, it is: ○ Getting Better ○ Getting worse ○ Unchanged

What makes your symptoms worse: ○ Standing ○ Walking ○ Lifting ○ Twisting ○ Stairs

○ Exercise ○ Squatting ○ Kneeling ○ Sitting ○ Coughing ○ Sneezing ○ Bending ○ Lying in bed

What makes your symptoms better?: ○ Rest ○ Elevation ○ Ice ○ Heat Other:_____

Patient Name: _____

PAST MEDICAL HISTORY

List all previous hospitalizations : ○ None

	YEAR
_____	_____
_____	_____
_____	_____
_____	_____

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

List any medications you are taking on a regular basis (including hormonal replacement therapy or birth control):

○ None	Medication	Reason
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_ _____	_____

Are you allergic to any medications? ○ Y ○ If Yes, please list below:

Medication	Reaction
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Other Allergies? ○ Y ○ N If Yes, what are they? _____ Latex allergy? ○ Y ○ N

Do you have a personal history or any of the following? ○ NONE

○ Excessive or Prolonged Bleeding	○ Rheumatic Fever	○ HIV / AIDS	○ Stroke
○ Blood Clots	○ Diabetes Type: _____		○ Circulatory Problems
○ Asthma	○ Reaction to Anesthesia Type: _____		○ Heart Disease /Defect
○ Stomach Ulcers	○ Cancer Type: _____		○ Chemotherapy /Radiation
○ Birth Defects	○ Arthritis Type: _____		○ Continuous Seizures
○ Problems with Wounds Healing	○ Hepatitis	○ Fractures /Joint Dislocations	○ Epilepsy
○ Emphysema	○ Bone or Joint Infections	○ Tuberculosis	○ Lung Disease
Are you Pregnant? ○ Y ○ N	○ Abnormal Blood Pressure	○ Chemical Dependency	○ Psychiatric Care
Claustrophobic? ○ Y ○ N	○ Pacemaker	○ Sleep Apnea	Use a C PAP? ○ Y ○ N

Patient Name: _____

REVIEW OF SYSTEMS

HAVE YOU HAD PROBLEMS IN THE PAST 6 MONTHS?					NONE	COMMENTS
1) GI	○ Heartburn, Ulcers	○ Nausea, Vomiting	○ Blood in Stool		○	_____
2) ENDO	○ Thyroid Disease	○ Heat or Cold Intolerance			○	_____
3) CON	○ Weight Loss	○ Loss of Appetite	○ Fatigue		○	_____
4) EYE	○ Blurred Vision	○ Double Vision	○ Vision Loss		○	_____
5) ENT	○ Hearing Loss	○ Hoarseness	○ Trouble Swallowing		○	_____
6) CV	○ Chest Pain	○ Palpitations			○	_____
7) RS	○ Chronic Cough	○ Pneumonia	○ 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	○ Numbness	○	_____
11) PSY	○ Depression / Anxiety	○ Drug / Alcohol Addiction	○ Sleep Disorder		○	_____
12) HEM	○ Easy Bleeding	○ Easy Bruising	○ Anemia		○	_____

FAMILY HISTORY

HAVE ANY DIRECT RELATIVES HAD ANY OF THE FOLLOWING DISORDERS?						
FATHER:	○ None	○ Diabetes	○ Anesthesia Problems	○ High Blood Pressure	○ Bleeding Problems	○ Rheumatoid Arthritis
MOTHER:	○ None	○ Diabetes	○ Anesthesia Problems	○ High Blood Pressure	○ Bleeding Problems	○ Rheumatoid Arthritis
SIBLING:	○ None	○ Diabetes	○ Anesthesia Problems	○ High Blood Pressure	○ Bleeding Problems	○ Rheumatoid Arthritis

SOCIAL HISTORY

Do you use tobacco? ○ Y ○ N If Yes, packs per day _____ ○ Quit

Alcohol use? ○ Y ○ N ○ Quit

Marital History: ○ Married ○ Single ○ Divorced ○ Widowed

Are you currently working? ○ Y ○ N ○ Retired ○ Disabled If no, when did you last work? _____

Are you currently on any work restrictions? ○ Y ○ N If Yes, what are they? _____

Occupation: _____ Employer: _____ ○ Student

○ If this box is checked, this form was completed by the patient, and I agree that the information above is correct and true.

○ If this box is checked, this form was completed with the assistance of _____and I, the patient, agree that the information above is correct and true.

_____ _____

Signature Date