

The Center for Orthopedic Care
Medical History Form

Name: _____ Date of Birth: _____ Age: _____

PHONE NUMBERS (circle preferred method of contacting you):

Home: (____) _____ Office: (____) _____
Mobile: (____) _____ Fax: (____) _____

EMAIL ADDRESS (if you want information by E-mail): _____

OTHER PHYSICIANS: Primary/Internist _____
Other Specialist _____

CHIEF COMPLAINT (reason for visit in one sentence): _____

Please specify if LEFT or RIGHT extremity involved.

When did symptoms begin (date of injury, rough estimate of onset)? _____

Please indicate if this is due to MVA _____ Liability _____ Worker's Compensation _____

SPECIFY SYMPTOM COMPONENTS (please elaborate as able, include location, severity, when occurs, quality, duration, context, associated symptoms): _____

PAST MEDICAL HISTORY Please list all hospitalizations (including surgeries) with problem, approximate date, location of hospital, and treating physician:

Problem	Date	Hospital	Physician
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List all medications with dosage and frequency, be sure to include MAO inhibitors, anticoagulants:

<u>Medications</u> (attach list if extensive)	<u>Dosage</u>	<u>Frequency</u>
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Drug and Food Allergies or Adverse Reactions (include penicillin, aspirin, anti-inflammatory drugs, local anesthetic):

SOCIAL HISTORY:

Marital Status: Single / Married / Separated / Divorced / Widow(er)

Children's Names and Ages: _____

Living Situation: Apartment / House Number of stairs you must negotiate daily at home _____
Alone / Caretaker / Nursing home facility

Town you live in: _____

Tobacco: _____ packs per day for _____ years

Cigars: _____ per week for _____ years

Alcohol: _____ 1 ½ ounce drinks or glasses or wine or beer per DAY or WEEK (please circle)

Education: _____ years Degree: _____

Occupation: _____

Handedness (if upper extremity problem, circle): Right Left

FAMILY HISTORY: List any diseases (i.e.-osteoarthritis, rheumatoid arthritis, heart disease, hormone abnormalities, diabetes, thyroid) that run in your blood relations (grandparents, parents, siblings, and children), do not include your spouse _____

REVIEW OF SYSTEMS: Please circle items that apply only to yourself, not to others or your relatives

General Health: Excellent Good Fair Poor

Height: _____ **Weight:** _____ (Indicate constant, recent loss, recent gain)

Eyes/Ear/Nose/Throat/Mouth: History of cataracts, cataract surgery, glaucoma, eyeglass use, dentures full/partial, last dental exam date:

Cardiovascular: chest pain, chest pressure, angina, myocardial infarction, heart attack, angioplasty, coronary artery bypass, shortness of breath, shortness of breath on exertion, unable to walk one flight of stairs, dizziness, unable to sleep flat at night with use of multiple pillows, ankle swelling, fainting, leg vein inflammation and thrombosis, varicose veins, varicose vein stripping

Respiratory: history of pneumonia, bronchitis, asthma, wheezing, pulmonary embolism, blood clots, pleurisy, cancer

Gastrointestinal: peptic ulcer disease, gastritis, esophageal reflux, hiatal hernia, frequent antacid use, upper intestinal bleeding, inflammatory bowel syndrome, diarrhea, hepatitis, jaundice, gall stones, gall bladder removal, hemorrhoids, polyps

Genitourinary: kidney stones, urinary tract infections, sexually transmitted diseases, frequency of urination, hesitancy, need to pass urine at night, bladder tumors, kidney abnormalities, blood in urine, prostate disease, prostate cancer, last prostate specific antigen date and result

Familial Muscular Diseases: muscular dystrophy, malignant hyperthermia, scoliosis, familiar skeletal dysplasias, hereditary bone conditions

Skin and Breast: psoriasis, infections, keloids, fibrocystic breast disease, breast cancer, mastectomy

Neurological/Psychological: seizures, strokes, neck pain, back pain, weakness, numbness, multiple sclerosis, tremor, unsteady gait, coordination problems, Parkinsonism, Alzheimer's Disease, forgetfulness, depression, anxiety, mania, psychosis, neurosis, history of MAO inhibitor drug use

Endocrine (hormone conditions): diabetes, thyroid disease, parathyroid disease

Hematological/Lymphatic: anemia, leukemia, lymphoma, blood clotting problems, Sickle Cell anemia, Thallesemia, Gaucher's Disease

Allergic/Immunological: HIV infection, AIDS, food allergy, hay fever, LATEX allergy

Patient Signature: _____

Date: _____

Reviewed: _____