CENTER FOR ADVANCED ORTHOPAEDICS & SPORTS MEDICINE, PC

MEDICAL HISTORY FORM

Name: _____ **Today's Date:** _____

SS#: _____ **Date of Birth:** _____ **Height:** _____ **Weight:** _____

CHIEF COMPLAINT:

Why are you visiting the office today?_____

Current problem is a result of: ___ Car Accident ___ Work Accident ___ Other (Explain) _____

Have you ever been treated for this condition before? ___No ___Yes By whom? _____ When? _____

MEDICATIONS: ***Please list***

Name	Dose	Frequency	Reason for Medication	Side Effects

MEDICAL HISTORY: ***Please list any current or previous medical issues (ex. Diabetes, high blood pressure, anxiety, etc.)***

_____

ALLERGIES TO MEDICATIONS: _____

ALLERGY TO LATEX: ___Yes ___No

Immunizations up to date? ___Yes ___No Date of last flu shot: _____ Date of last pneumonia shot: PCV13_____ PPV23_____

SURGICAL HISTORY: ***Please list***

Surgery Performed	Year	Complications

Have you ever had general anesthesia? ___Yes ___No

Did you have any problems with anesthesia? ___Yes ___No If yes, describe:_____

HOSPITALIZATIONS: ***Please list***

Reason for Hospitalization	Year	Complications

FAMILY HISTORY:

	Alive	Deceased	Age	Medical conditions, Cause of death
Father	___	___	___	_____
Mother	___	___	___	_____
Paternal Grandfather	___	___	___	_____
Paternal Grandmother	___	___	___	_____
Maternal Grandfather	___	___	___	_____
Maternal Grandmother	___	___	___	_____

		Ages	Medical conditions
Siblings:	# of brothers___	_____	_____
	# of sisters___	_____	_____

SOCIAL HISTORY:

Tobacco Use: ___Current Smoker: ___Heavy (20-39 cigs/day) ___Moderate (10-19 cigs/day) ___Light (1-9 cigs/day)
___Former Smoker: ___Heavy (20-39 cigs/day) ___Moderate (10-19 cigs/day) ___Light (1-9 cigs/day)
How long since you last smoked?_____
___Non-Smoker

Drugs: Have you used drugs other than those prescribed to you? ___Yes ___No If yes, which?_____

Alcohol: How often did you have a drink containing alcohol in the past year?
___Never ___Monthly or less ___2-4x/month ___2-3x/week ___4+times/week

How many drinks did you have on a typical day when you were drinking?
___1-2 drinks ___3-4 drinks ___5-6 drinks ___7-9 drinks ___10+drinks

How often did you have 6 or more drinks on one occasion in the past year?
___Never ___Less than once a month ___Monthly ___Weekly ___Daily or almost daily

Children? ___Yes ___No If yes, how many?_____

Living with: ___Alone ___Spouse ___Significant Other ___Family ___Friend(s)

Marital Status: ___Single ___Married ___Separated ___Divorced ___Widowed

ORTHOPAEDIC HISTORY:

Hand Dominance: ___Right ___Left

Occupation_____ or ___Unemployed ___Self-Employed ___Retired ___Disabled ___Student

Previous Fractures: Bone Date Treatment

_____

_____

REVIEW OF SYSTEMS:

Are you currently having or have you ever had any problems with: (circle "yes" or "no" & describe all "yes" responses)

Eyes	No	Yes	_____
Ears, Nose, Throat	No	Yes	_____
Lungs, Breathing	No	Yes	_____
Digestion	No	Yes	_____
Bowel Movements	No	Yes	_____
Bladder Problem	No	Yes	_____
Diabetes	No	Yes	_____
High Blood Pressure	No	Yes	_____
Bleeding Problems	No	Yes	_____
Balance Problems	No	Yes	_____
Numbness/Tingling	No	Yes	_____
Blackouts/Fainting	No	Yes	_____
Psychological Problems	No	Yes	_____
AIDS	No	Yes	_____
Cancer	No	Yes	_____
Arthritis	No	Yes	_____
Polio	No	Yes	_____
Tuberculosis	No	Yes	_____
Epilepsy	No	Yes	_____

PATIENT SIGNATURE:_____ DATE:_____

PROVIDER SIGNATURE:_____ DATE:_____