

ORTHOPAEDIC ASSOCIATES

Medical History Form

Appointment Date: _____ With Dr. _____ Chart # _____

Patient Name: _____ Age: _____ Sex: F M Height: _____ Wt: _____

ALLERGIC TO ANY MEDICATIONS? No Yes List allergies: _____

Please explain reason for this visit. Please list involved body parts, and comment on whether you have pain, numbness, weakness, swelling, stiffness, or other symptoms:

How long ago did this start? _____ **How did you hurt yourself?** _____

Did you go to the Emergency Room? No Yes **Date of E.R. visit:** _____

Were X-rays taken? No Yes **From which hospital:** Phoebe Palmyra Other: _____

Were you injured for this problem on the job? No Yes **Date of Injury:** _____

What treatments have you tried thus far?

<input type="checkbox"/> medications	<input type="checkbox"/> physical therapy	<input type="checkbox"/> brace
<input type="checkbox"/> cane/crutch	<input type="checkbox"/> injections	<input type="checkbox"/> chiropractic treatment

Surgery for this same problem? Please list procedure, surgeon and date: _____

Current Work Status: Regular Light Duty Not Working Now Disabled Retired Student

When is the last date you worked at your regular job? _____

Workers Comp? No Yes

PAST MEDICAL HISTORY

Do you have, or have you ever had, any of the following? (Check all that apply)

<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Stroke	<input type="checkbox"/> Hepatitis/Jaundice
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Kidney Problems or Failure	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> Diabetes Controlled with <input type="checkbox"/> insulin <input type="checkbox"/> pills <input type="checkbox"/> diet	<input type="checkbox"/> Seizures	<input type="checkbox"/> Asthma/Emphysema
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Cancer: where?	<input type="checkbox"/> Ulcer/Acid Reflux
<input type="checkbox"/> Blood Clot	<input type="checkbox"/> Depression	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Anemia or Bleeding Disorder	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Rheumatoid Arthritis

Surgeries (check all that apply, and list below those not outlined here):

Appendectomy Tonsillectomy Gallbladder Hysterectomy Cataracts Hernia

