Medical History Form
(Please use black ink)

Patient Name: ______________________ Date of Birth: __________ Appointment Date: __________

Age:_____ Sex: ▫ F ▫ M Height: ______Weight: ______ Dominant hand: ▫ R ▫ L Latex Allergy? ▫ Y ▫ N

What body part is involved? (Please mark the table below)

Shoulder	Elbow	Wrist	Hand	Hip	Knee	Ankle	Foot	Neck	Back
▫ R ▫ L	▫ R ▫ L	▫ R ▫ L	▫ R ▫ L	▫ R ▫ L	▫ R ▫ L	▫ R ▫ L	▫ R ▫ L	▫ R ▫ L	▫ R ▫ L

How long ago did it start?_____ Days_____ Weeks______ Months______ Years.

Have you had a problem like this before: ▫ Y ▫ N

Check the ONE BOX which best described HOW your problem started. Then answer the questions below the box you checked. Use as much space to the right as needed.

- ☐ NO INJURY (or onset was: ▫ Gradual or ▫ Sudden)
- ☐ INJURY (▫ Sport ▫ Accident (NOT Auto or Work)
  - Date:___________ What Sport?___________ School?__________________
- ☐ INJURY AT WORK
  - Date:___________ From a: ▫ Lift ▫ Twist ▫ Fall ▫ Bend ▫ Pull ▫ Reach
- ☐ WORK RELATED BUT NO INJURY
  - Date:___________ How did your job cause the problem?__________________________
- ☐ AUTO ACCIDENT
  - Date:___________ How was your car hit?_____________________________

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 the pain? ▫ Sharp ▫ Dull ▫ Stabbing ▫ Throbbing ▫ Aching ▫ Burning

The pain is: ▫ Constant ▫ Comes and goes (intermittent)

Does your pain wake you from your sleep? ▫ Y ▫ N

Do you have: ▫ Swelling ▫ Bruises ▫ Numbness ▫ Weakness ▫ Tingling
▫ Loss of control of bowel or bladder ▫ Locking/Catching ▫ Giving way

Since my problem started, it is: ▫ Getting better ▫ Getting worse ▫ Unchanged

What makes your symptoms worse? ▫ Standing ▫ Walking ▫ Lifting ▫ Exercise ▫ Twisting ▫ Lying in bed
▫ Bending ▫ Squatting ▫ Kneeling ▫ Stairs ▫ Sitting ▫ Coughing ▫ Sneezing

Which makes your symptoms better? ▫ Rest ▫ Elevation ▫ Ice ▫ Heat ▫ Other:__________________

Have you had any of these treatments? Injection: ▫Y ▫N Brace: ▫Y ▫N Physical Therapy: ▫Y ▫N Cane/Crutch: ▫Y ▫N

Were you seen in the E.R. for this problem? ▫ Y ▫ N Which E.R.? _______________ Date: _____________

What tests have you had for this problem?
▫ X-Rays ▫ MRI ▫ CT Scan ▫ Bone Scan ▫ Nerve Test (EMG/NCV) Where? ____________________

Have you had a prior problem with this same orthopaedic condition in the past? ▫ Y ▫ N (explain below)

____

Have you already had surgery for a problem in this same area either recently or in the past? ▫ Y ▫ N

Please list below:

Procedure #1_______________ Surgeon _________________City______________ Date__________
Procedure #2_______________ Surgeon _________________City______________ Date__________

List all medications you are currently taking: ______________________________________

____

ALLERGIC TO ANY MEDICATIONS AND/OR FOODS? ▫ Y ▫ N If yes, please list and describe reaction:____

ALLERGIC OR SENSTIVE TO ANY METALS? ▫ Y ▫ N If yes, please list and describe reaction:____

Review of Systems

Do your other joint have: ◻ morning stiffness lasting over 30 minutes ◻ joint pain or swelling ◻ Back Pain
◻ Gout ◻ Rheumatoid arthritis ◻ Osteoarthritis
◻ prior fracture (which bone)________________ ◻ None of these

Have you had any of these symptoms? If no, mark None.

					NONE	YEAR
1)	GI	◻ Heartburn, ulcers ◻ Hepatitis	◻ Nausea, Vomiting ◻ Liver disease	◻ Blood in Stool	◻	______
2)	ENDO	◻ Thyroid Disease	◻ Osteoporosis	◻ Heat/Cold Intolerance	◻	______
3)	CON	◻ Weight Loss	◻ Loss of Appetite		◻	______
4)	EYE	◻ Blurred Vision	◻ Double Vision	◻ Vision Loss	◻	______
5)	ENT	◻ Hearing Loss	◻ Hoarseness	◻ Trouble Swallowing	◻	______
6)	CV	◻ Chest Pain	◻ Palpitations		◻	______
7)	RS	◻ Chronic Cough	◻ 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	◻	______
11)	PSY	◻ Depression	◻ Sleep Disorder	◻ Drug/Alcohol Addiction	◻	______
12)	HEM	◻ Easy Bleeding	◻ Easy Bruising	◻ Anemia	◻	______

13) ARE YOU HIV POSITIVE: ◻ Y ◻ N

COMMENTS:____

PAST MEDICAL HISTORY:

Are you Diabetic? ◻ Y ◻ N If Yes, treatment: ◻ Insulin ◻ Oral Medications ◻ Diet ◻ None

Are you taking, or have you ever taken, blood thinners? ◻ Y ◻ N If yes, which one?____________________

Past Surgical History: What operations have you had and when? Please list:

____

____

Have you or a family member ever had a reaction to anesthesia? ◻ Y ◻ N EXPLAIN:

____

Past Hospitalizations (Not for Surgery) List Below: ◻ None

____

____

Have you ever had: ◻ Heart attack (year_____) ◻ High Blood Pressure ◻ Blood Clots (year______) ◻ Stroke
◻ Heart Failure ◻ Ankle Swelling ◻ Kidney failure ◻ Cancer (location___________) ◻ Colorectal Cancer
◻ Stomachache while taking anti-inflammatories (including Advil/Aleve) What anti-inflammatories have you already had a problem with?____
◻ Influenza Vaccine ◻ Pneumovax ◻ Mammogram ◻ Incontinence

FAMILY HISTORY:

Have any direct relatives had any of the following disorders? If so, which relatives?
◻ Diabetes _________________ ◻ High Blood Pressure _____________ ◻ Rheumatoid Arthritis ____________ ◻ NONE
Do any direct relatives have the same condition you are being seen for today? ◻ Y ◻ N

____

SOCIAL HISTORY:

Do you use tobacco? ◻ Y ◻ N If yes, packs per day _____ Patient informed of Smoking Risk? ◻ Y ◻ N
Alcohol use? ◻ Y ◻ N If yes, how often? ◻ Daily ◻ Other _____/week
Marital History: ◻ M ◻ S ◻ D ◻ W How many people live with you? ____________________
Occupation: ______________________ ◻ Student
Employer:____
Current work status: ◻ Regular ◻ Light duty – (how long?_____________) ◻ Not working due to this problem
◻ Disabled ◻ Retired ◻ Student
When is the last day you worked your regular job?____
Do you plan to be working 6 months from now? ◻ Y ◻ N

PLEASE SIGN: This information on this form is accurate to the best of my knowledge.

____
Signature Date

____
Provider