

Medical History Information

Name of Patient: _____ . I certify to the best of my knowledge that all information is correct. I authorize Orthopaedics, P.C. to release all medical records they have regarding myself or my child to my family physician and/or referring physician relating to this illness/injury.

Signature _____ Date _____

Present History:

What is your chief complaint for this visit?

Date of accident or onset of symptoms:

Describe how your symptoms started (if due to injury, how were you injured?)

Have you had any treatment for this condition to date? _____ Yes _____ No

If yes, please indicate treatment: _____ Hospitalization _____ Surgery
_____ Therapy _____ Medication _____ X-rays _____ Injections

Date _____ By whom _____

Have you ever had similar symptoms prior to this episode? _____ Yes _____ No

Are you working at this time? _____ Yes _____ No Any restrictions? _____

Family History:

Is there a family history of: _____ High blood pressure _____ Heart disease
_____ Diabetes _____ Cancer _____ Anesthesia problems
_____ Rheumatoid arthritis?

Surgical History:

Social History:

Do you smoke? _____ Yes _____ No How much?

How often do you drink alcohol in a week?

How many drinks at a time?

Your height _____ Your weight _____

Have you had a bone densitometry? _____ Yes _____ No

Have you had a blood transfusion? _____ Yes _____ No

Have you ever been told you have a blood antibody? _____ Yes _____ No

Review of Systems:

Have you ever had any of the following? Please answer Yes or No.

| | | |
|--------------------------|-----------------------|--------------------|
| _____ Breathing problems | _____ Kidney problems | _____ Heart attack |
| _____ Cancer | _____ Ulcers | _____ Hepatitis |
| _____ Stroke | _____ AIDS | _____ Diabetes |
| | | _____ Rheumatoid |

arthritis

Current Medical Problems

