EAST COAST ORTHOPAEDICS

# MEDICAL HISTORY FORM

Patient Name: _____ Date of Birth: _____

Age: _____ Sex: ○ M ○ F Height: _____ Weight: _____ ○ Right Handed ○ Left Handed

Race: ○ Caucasian ○ African American ○ Asian ○ Other_____

Ethnicity: ○ Non-Hispanic ○ Hispanic ○ Unknown ○ Declined to Answer

Preferred Language: ○ English ○ Spanish ○ Chinese ○ Other: _____

Pharmacy: _____ Location: _____ Phone #_____

Referring Physicians Name: _____

Reason for Visit: _____ ○ L ○ R ○ Bilateral

List Contributing events or known causes: _____
_____

Please describe the onset of symptoms by choosing ONE item below:

○ No Injury- gradual onset of symptoms Symptoms began: (# of)_____ ○ days ○ weeks ○ months ago

○ Work Injury on _____ (date of injury)

○ Motor Vehicle Accident on _____ (date of injury)

○ Other Injury: on _____ (date of injury)

(please explain)_____

Do symptoms include pain? ○ Y ○ N

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

Frequency of Pain: ○ Constant ○ Intermittent (comes & goes) ○ Progressive ○ Not Progressive

Describe your pain: ○ Sharp ○ Dull ○ Stabbing ○ Burning

Do Symptoms Include: ○ Swelling ○ Weakness ○ Numbness ○ Decreased Range of Motion ○ Pins/Needles Sensation

Since the problem started, it is: ○ Getting Better ○ Getting worse ○ Unchanged

Do you have difficulty: ○ Crossing your legs ○ Putting on shoes& socks ○ Getting in/out of the car ○ Going up or down stairs

How far can you walk before you notice pain? _____

If applicable, is the joint: ○ Popping ○ Locking ○ Clicking ○ Instability/giving way ○ Bending

Past Treatment of your current problem: (select all that apply)

○ Ice Treatment ○ Physical Therapy ○ Heat Treatment ○ Prescription Medication ○ Use of cane or walker ○ Injections

#_____ ○ Rest How long?_____ ○ Anti Infammatories- Advil, Motrin, Aleve, Ibuprofen

Patient Name: _____

## PAST MEDICAL HISTORY

Current Medications :

| ○ None | Medication | Dosage |
|---|---|---|
| | _____ | _____ |
| | _____ | _____ |
| | _____ | _____ |
| | _____ | _____ |
| | _____ | _____ |

Allergies (not seasonal) ○ No known Allergies

○ Penicillin ○ Aspirin ○ Codeine ○ Tylenol ○ Iodine ○ Sulfer ○ Shellfish ○ Latex Allergy

○ Adhesive Tape ○ Other: _____

Have you been diagnosed with any of the following? ○ NONE

| | | | |
|---|---|---|---|
| ○ Alcoholism | ○ COPD | ○ High Cholesterol | ○ Neurological Disorders |
| ○ Arthritis | ○ Diabetes Type: _____ | | ○ Osteoporosis |
| ○ Anemia | ○ GERD | | ○ Pacemaker |
| ○ Blood Clots | ○ GI Disorders | | ○ Renal Disease |
| ○ Blood Transfusion | ○ Heart Disesase - Specify_____ | | ○ Rheumatoid Arthritis |
| ○ Bronchitis | ○ Hepatitis Type: _____ | ○ HIV/ AIDS | ○ Stroke |
| ○ Cancer | ○ Hernia | ○ Kidney Disease | ○ Thyroid Disease |
| ○ Other: _____ | ○ High Blood Pressure | ○ Liver Disease | |
| Are you pregnant? ○ Y ○ N | | Are you claustrophobic? ○ Y ○ N | |

PAST SURGERY

| | | |
|---|---|---|
| ○ Appendectomy | ○ D&C | ○ Neck Surgery |
| ○ Arthroscopy | ○ Gallbladder Surgery | ○ Pacemaker |
| ○ Back Surgery | ○ Heart Bypass | ○ Prostate Surgery |
| ○ Breast Surgery | ○ Heart Valve Replacement | ○ Skin Cancer |
| ○ Cataract Surgery | ○ Hernia Repair | ○ Tonsillectomy |
| ○ Carpal Tunnel | ○ Hysterectomy | |
| ○ Cesarean Section | ○ Kidney Surgery | |
| ○ Joint Replacement (specify joint)___ _____ | | |
| ○ Other Surgeries: _____ | | |

Patient Name: _____

## REVIEW OF SYSTEMS

| HAVE YOU HAD PROBLEMS IN THE PAST 6 MONTHS? | | | | | NONE | COMMENTS |
|---|---|---|---|---|---|---|
| 1) GI | ○ Heartburn, Ulcers | ○ Nausea, Vomiting | ○ Blood in Stool | | ○ | _____ |
| 2) ENDO | ○ Thyroid Disease | ○ Heat or Cold Intolerance | | | ○ | _____ |
| 3) CON | ○ Weight Loss | ○ Loss of Appetite | ○ Fatigue | | ○ | _____ |
| 4) EYE | ○ Blurred Vision | ○ Double Vision | ○ Vision Loss | | ○ | _____ |
| 5) ENT | ○ Hearing Loss | ○ Hoarseness | ○ Trouble Swallowing | | ○ | _____ |
| 6) CV | ○ Chest Pain | ○ Palpitations | | | ○ | _____ |
| 7) RS | ○ Chronic Cough | ○ Pneumonia | ○ 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 | ○ Numbness | ○ | _____ |
| 11) PSY | ○ Depression / Anxiety | ○ Drug / Alcohol Addiction | ○ Sleep Disorder | | ○ | _____ |
| 12) HEM | ○ Easy Bleeding | ○ Easy Bruising | ○ Anemia | | ○ | _____ |

## FAMILY HISTORY

| HAVE ANY DIRECT RELATIVES HAD ANY OF THE FOLLOWING DISORDERS? | | | | | | |
|---|---|---|---|---|---|---|
| FATHER: | ○ None | ○ Diabetes | ○ Anesthesia Problems | ○ High Blood Pressure | ○ Bleeding Problems | ○ Rheumatoid Arthritis |
| MOTHER: | ○ None | ○ Diabetes | ○ Anesthesia Problems | ○ High Blood Pressure | ○ Bleeding Problems | ○ Rheumatoid Arthritis |
| SIBLING: | ○ None | ○ Diabetes | ○ Anesthesia Problems | ○ High Blood Pressure | ○ Bleeding Problems | ○ Rheumatoid Arthritis |

## SOCIAL HISTORY

Smoking Status: ○ Current every day smoker: # ____packs ○ Occasional smoker #_____ packs

○ Previous Smoker ○ Never Smoker

Alcohol use? ○ None ○ Social ○ Frequent

Marital History: ○ Married ○ Single ○ Divorced ○ Widowed

Are you currently working? ○ Y ○ N ○ Retired ○ Disabled

Occupation: _____ Employer: _____ ○ Student

_____ _____

Signature Date