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