

Tristate Orthopaedic Treatment Center

Patient Medical History Form

Last Name: _____ First Name: _____ MI: _____ Today's Date: _____

DOB: _____ Age: _____ SSN: _____ Marital Status: M S D W

Height: _____ Weight: _____ lbs. Occupation: _____

My injury is: Work Related from ____/____/____ Due to a Car Accident from ____/____/____ None of the Above

ALLERGIES

Medications: None Penicillin Sulfa Cephalosporins Aspirin Horse Serum Other _____

Metals: Nickel Cobalt Chromate Other _____ Food: _____

Other Allergies Not Listed: _____

MEDICATIONS: Please provide a typed medication list if necessary.

NAME	DOSE	FREQUENCY	NAME	DOSE	FREQUENCY

SURGERY/HOSPITALIZATIONS

TYPE OF SURGERY OR MEDICAL CONDITION	YEAR	TYPE OF SURGERY OR MEDICAL CONDITION	YEAR

Did you have any surgical complications? Yes No Did you ever have a Staph (MRSA) infection? Yes No

PAST / FAMILY MEDICAL HISTORY: Check if any of these apply to yourself or anyone in you family.

	<u>YOU</u>	<u>FAMILY</u>		<u>YOU</u>	<u>FAMILY</u>		<u>YOU</u>	<u>FAMILY</u>
Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
Disk Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	Strokes	<input type="checkbox"/>	<input type="checkbox"/>
Spine Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Birth Defects	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>	Nerve/Psych Disease	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Colon/Intestinal Disease	<input type="checkbox"/>	<input type="checkbox"/>

PERSONAL HABITS

Smoking: Yes No How many packs per day? _____ How many years? _____
 Alcohol consumption: Yes No How many drinks/beer per day? _____ week? _____ month? _____
 Recreational drugs: Yes No If yes, please explain _____

SOCIAL HISTORY

Psychiatric Disease Yes No Drug Addiction Yes No If yes, please explain _____
 Supportive family Yes No in immediate area? Yes No
 Education level _____ last grade attended.
 Do you walk outside your house? Yes No If YES, do you use any of the following: Cane Walker Other _____

PRESENTING PROBLEM

Have you had any diagnostic studies other than routine x-rays? Yes No If yes, what type _____
 What other type of doctors have you seen for your current problem? (e.g. chiropractor) _____
 Have you had surgery for this current problem? Yes No If Yes, when _____
 Do you have any additional information that would be helpful to understand your problem? _____

PLEASE TURN PAGE OVER. THANK YOU.

Physician Signature _____ Date _____

REVIEW OF SYSTEMS

Please check any of the following health problems that apply to you personally.

GENERAL HEALTH

Good general health lately _____
Recent weight change _____
Fever _____
Fatigue _____
Headaches _____
Loss of appetite _____

EYES

Eye disease or injury _____
Wear glasses/contact lens _____
Blurred or double vision _____
Glaucoma _____

EARS/NOSE/MOUTH/THROAT

Hearing loss or ringing _____
Earaches or drainage _____
Chronic sinus problem or rhinitis _____
Nose bleeds _____
Mouth sores _____
Bleeding gums _____
Bad breath or bad taste _____
Sore throat or difficulty swallowing _____
Swollen glands in neck _____

CARDIOVASCULAR

History of pulmonary embolism _____
Heart trouble _____
Chest pain or angina pectoris _____
Palpation _____
Shortness of breath with walking or lying flat _____
Severe cramping in legs when walking _____
Swelling of feet, ankles or hands _____

RESPIRATORY

Chronic or frequent coughs _____
Spitting up blood _____
Shortness of breath _____
Asthma or wheezing _____

GASTROINTESTINAL

Loss of appetite _____
Change in bowel movements _____
Nausea or vomiting _____
Frequent diarrhea _____
Painful bowel movements or constipation _____
Rectal bleeding or blood in stool _____
Abdominal pain or heartburn _____
Peptic ulcer (stomach or duodenal) _____

GENITOURINARY

Frequent urination _____
Burning or painful urination _____
Blood in urine _____
Change in force or strain when urinating _____
Incontinence or dribbling _____
Kidney stones _____
Sexual difficulty _____
Urinary tract infections _____
Enlarged prostate _____

MUSCULOSKELETAL

Joint pain, stiffness or swelling _____
Shooting leg pain _____
Weakness of muscles or joints _____
Muscle pain or cramps _____
Back pain _____
Cold extremities _____
Difficulties in walking or standing _____
Frequent dislocations _____

SKIN CONDITIONS (skin, breast)

Rash or itching _____
Change in skin color _____
Change in hair or nails _____
Varicose veins _____
Breast pain/lump/discharge _____
Painful bumps on the skin _____

NEUROLOGICAL

Frequent or recurring headaches _____
Nighttime cramps _____
Convulsions or seizures _____
Numbness or tingling sensations _____
Tremors _____
Paralysis _____
Stroke _____
Head injury _____
Claustrophobia _____

PSYCHIATRIC

Memory loss or confusion _____
Nervousness _____
Panic Attacks _____
Depression _____
Insomnia _____

ENDOCRINE

Glandular or hormone problem _____
Thyroid disease _____
Diabetes _____
Excessive thirst or urination _____
Heat or cold intolerance _____
Skin becoming dryer _____
Excessive facial hair _____

HEMATOLOGIC/LYMPHATIC

Slow to heal after cuts _____
Bleeding or bruising tendency _____
Anemia _____
Phlebitis or Blood clot _____
Past transfusion- blood or platelet _____
Enlarged glands _____

ALLERGIC/IMMUNOLOGIC

History of skin reaction or other adverse reaction to:
Penicillin or other antibiotics _____
Morphine, Demerol, or other narcotics _____
Novocaine or other anesthetics _____
Aspirin or other pain remedies _____
Tetanus antitoxin or other serums _____
Iodine, merthiolate or other antiseptics _____
Other drugs/medications _____

Patient Signature _____ Date _____