Northern Pines Orthopaedic Clinic

MEDICAL HISTORY FORM for ______________________________/_______/ Male/Female
(patient name) (age) (circle one)

PAST MEDICAL HISTORY – Circle any of the medical problems listed below that you have now:

A. I have no known medical problems
B. Arthritis
C. Asthma
D. Blood clots: Y / N ; where _____________
E. Cancer, what type: ___________________
F. COPD/lung problem/emphysema
G. Coronary artery disease/heart disease
H. Diabetes
I. Gout
J. Heart attack
K. Hepatitis – A, B, C (please circle type)
L. High cholesterol
M. High blood pressure
N. Immune disorder
O. Liver diseases
P. Osteomyelitis
Q. Osteoporosis
R. Peripheral vascular disease
S. Seizure disorder
T. Thyroid disorder
U. Ulcers
V. Other: _______________________________
____

PAST SURGICAL HISTORY – Circle any of the surgeries listed below that you have had. Indicate the year of the surgery if known.

A. No previous surgeries _______________
B. Appendectomy ____________________
C. Cataract extraction _________________
D. Blood transfusion __________________
E. By-pass/open heart _________________
F. Cardiac stents _____________________
G. Gallbladder _______________________
H. Hernia repair ______________________
I. Hysterectomy _________________
J. Mastectomy __________________
K. Orthopaedic surgery/fractures _____________
L. Prostate surgery _______________
M. Spine surgery ________________
N. Tonsillectomy ________________
O. Other (specify): ________________________
____

Previous broken bones or other treatment? No Yes (please list): ______________________________
____
____

ARE YOU RIGHT OR LEFT HANDED? (Please circle) Right Left

ALLERGIES – Circle anything listed below to which you are allergic:

A. No known allergies
B. Adhesive tape
C. Codeine
D. Erythromycin
E. Iodine/Betadine
F. Latex
G. Morphine
H. Penicillin
I. Radiographic dyes
J. Sulfa
K. Tetracycline
L. Other (specify): ________________

What medications are you currently taking? Please include prescription, non-prescription and herbal supplements:

Medication	**Dose**	**# Times a Day**
________________________	____________	____________________
________________________	____________	____________________
________________________	____________	____________________
________________________	____________	____________________

NAME OF YOUR PHARMACY: ______________________________
DATE OF INJURY: ______________________ WHERE DID INJURY OCCUR? _______________

(home, work, etc.)

REFERRING PHYSICIAN: ______________________ **PRIMARY PHYSICAN** ______________

Continued on next page… **(if different)**

Please rate your pain on a scale of 1 – 10 (10 being the worst): 0 1 2 3 4 5 6 7 8 9 10

Do you feel safe? Yes No

Has your weight changed more than 10 pounds in the past 6 months? Yes No

Have you changed your eating habits? No Yes, please explain: ___________________________

____

SOCIAL HISTORY – How much alcohol do you consume?

A. I'm a non-drinker

B. I'm a recovering alcoholic

C. I drink only occasionally

D. I drink _______ times per week

Employed? _______________

____

Hobbies: ________________

____

Single Widow

Married Partner

Divorced

Children: _________________

Do you now or have you ever smoked cigarettes?

A. I have smoked _____ packs/day for _____ years

B. No, but I used to smoke and smoked for _____ years

C. No, I have never smoked

Do you now or have you ever used drugs? No Yes (circle all that apply): A. Cocaine B. Marijuana C. Heroine D. Methamphetamine E. Other (specify): ______________________________________

FAMILY HISTORY- Has anyone in your immediate family ever had any of the following? (circle which apply)

A. None known
B. Alcoholism
C. Asthma
D. Bleeding tendency
E. Cancer, what type: ___________________
F. Colitis
G. Diabetes
H. Heart disease/heart attack
I. High blood pressure
J. Rheumatic fever
K. Seizure disorder
L. Stroke
M. Thyroid problems
N. Tuberculosis
O. Other (specify): ____________________________
____

REVIEW OF SYSTEMS – Please circle all that apply to you:

General
Fatigue
Fevers
Poor sleep
Weight gain
Weight loss

Cardiac
Chest pain
Irregular heartbeat

Respiratory
Dry cough
Productive cough
Short of breath

Eyes, Ears & Throat
Difficulty hearing
Difficulty seeing
Poor swallowing

Gastrointestinal
Abdominal cramping
Constipation
Diarrhea
Nausea
Incontinence
Vomiting

Genitourinary
Blood in urine
Difficulty urinating
Leaking urine
Painful urination

Musculoskeletal
Back pain
Cramping
Joint stiffness
Neck pain

Neurological
Dizziness
Headaches
Loss of balance
Numbness
Weakness

Heme/Lymphatic
Bleeding
Bruising
Clotting disorder
Swelling

I have reviewed/completed the above ____ / _________________

(patient's signature) (Date)

Reviewed by ____ / ____________________

(doctor's signature) (Date)