



Medical History Form

Today's Date: _____
MM/DD/YYYY

Name: _____
First MI Last

Age: _____ Date of Birth: _____ Height: _____ Weight: _____
MM/DD/YYYY

Gender: Male Female Hand Dominance: Left Right Both

Family/Primary Care Physician: _____
Name City

I was sent to Orthopaedic Specialists of Springfield by:

- Family Doctor (Listed Above)
- Physician, other: Name: _____ City: _____
- Emergency Room: Hospital: _____ City: _____
- Other healthcare professional (nurse, therapist): Name: _____ City: _____
- Self-Referred
- Employer
- Insurance Plan
- Other: _____

Chief Complaint:

Problem that brings you to our facility: _____

Body Part: Neck Back Extremity _____ Left Right

Date of Injury/Onset: _____
MM/DD/YYYY

Do you have x-rays? Yes No What part of the body? _____ Right Left
If Yes, Where? _____ When? _____

Symptoms: (Check all that apply)

- pain numbness weakness stiffness instability swelling/mass

Severity: minor moderate severe

When do the symptoms occur? (Check all that apply)

- Daily Weekly Monthly
- During exercise At rest At night

Is the current problem the result of: Car accident? Work accident?

Other, please explain: _____

If a work accident, is this an approved workman's compensation? YES NO

Is this injury a liability claim? YES NO

Current Medications: None List any prescription, drugs, and/or non-prescription medications, including vitamins, nutritional supplements, or anything taken orally.

<i>List names of medications:</i>	<i>Dose or strength:</i>	<i>Reason for medication:</i>
1. _____	a. _____	b. _____
2. _____	a. _____	b. _____
3. _____	a. _____	b. _____
4. _____	a. _____	b. _____
5. _____	a. _____	b. _____
6. _____	a. _____	b. _____



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Today's Date: _____
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Allergies: No known allergies
Are you allergic to Latex? YES NO

<i>List allergies including allergies to medications:</i>	<i>Describe reaction:</i>
1. _____	a. _____
2. _____	a. _____
3. _____	a. _____
4. _____	a. _____

General Medical History: (check all that apply) **NO Medical problems**

- | | | | |
|--|---|---|--|
| <p><u>Neurological</u></p> <input type="checkbox"/> Stroke
<input type="checkbox"/> Migraine
<input type="checkbox"/> Concussion
<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Other: _____ | <p><u>Pulmonary</u></p> <input type="checkbox"/> Asthma
<input type="checkbox"/> Emphysema
<input type="checkbox"/> Pulmonary embolism
<input type="checkbox"/> Other: _____ | <p><u>Infectious</u></p> <input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> Hepatitis B
<input type="checkbox"/> Hepatitis C
<input type="checkbox"/> TB
<input type="checkbox"/> Recent tick bite
<input type="checkbox"/> Other: _____ | <p><u>Psychological</u></p> <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety
<input type="checkbox"/> ADHD
<input type="checkbox"/> Bipolar
<input type="checkbox"/> Schizophrenia
<input type="checkbox"/> Other: _____ |
| <p><u>Cardiovascular</u></p> <input type="checkbox"/> Heart Attack
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Coronary Artery Disease
<input type="checkbox"/> Other: _____ | <p><u>Gastrointestinal</u></p> <input type="checkbox"/> Ulcers
<input type="checkbox"/> Reflux
<input type="checkbox"/> Other: _____ | <p><u>Musculoskeletal</u></p> <input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/> Other: _____ | <p><u>Hematological</u></p> <input type="checkbox"/> Bleeding problems
<input type="checkbox"/> Blood clots |
| | <p><u>Endocrine</u></p> <input type="checkbox"/> Diabetes
<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Other: _____ | <p><u>Cancer</u></p> <input type="checkbox"/> Type: _____ | <p><u>Renal</u></p> <input type="checkbox"/> Kidney Failure
<input type="checkbox"/> Kidney Stones
<input type="checkbox"/> Other: _____ |

Other medical problems not listed above: _____
Have you ever had a blood transfusion? YES NO

Previous Surgery/Hospitalizations: **None**

<i>List surgery/Reason for hospitalization:</i>	<i>Hospital/Facility:</i>	<i>Date:</i>
1. _____	a. _____	b. _____
2. _____	a. _____	b. _____
3. _____	a. _____	b. _____
4. _____	a. _____	b. _____
5. _____	a. _____	b. _____
6. _____	a. _____	b. _____

Have you ever had General Anesthesia? YES NO
Have you ever had any problems with anesthesia? YES NO
If YES, please explain: _____

Family History: (Parents, siblings) **Unknown** **None**

Please List Family Member(s)

- | | |
|---|---|
| <input type="checkbox"/> Diabetes: _____ | <input type="checkbox"/> Cancer (Type): _____ |
| <input type="checkbox"/> Heart Disease: _____ | <input type="checkbox"/> Stroke: _____ |
| <input type="checkbox"/> Bleeding or clotting problems: _____ | <input type="checkbox"/> Other: _____ |

Social History:

- Marital Status: Single Married Other: _____
- Work Status: Employed (Occupation _____) Unemployed
 Disabled Student Retired
- Do you use tobacco products? YES NO Type of product: _____
 How Much? _____ How many years? _____
 Have you quit using products? YES NO If yes, when? _____
- Do you drink alcohol? Never Daily 1-2x/week 1-2x/month 1-2x/year
- Do you currently use or have a history of illicit substance use? YES NO
 If YES, what kind? _____
- Do you exercise? Daily Regularly Weekly Occasionally Never
 Type of exercise? _____
- Hobbies? _____
- What is your primary language? English Other (Specify): _____
- Do you have an Advance Directive? Yes No If Yes, with which facility? _____
- Do you have a Power of Attorney? Yes No
- Do you need more information on Advance Directive and/or Power of Attorney? Yes No

Review of Systems: Are you experiencing any of the following:

(Check all that apply) **None apply**

General

- Unexplained weight loss
- Fevers, chills, sweats
- Marked fatigue
- Difficulty Sleeping

Eye, Ear, Nose, Throat

- Difficulty swallowing
- Hoarseness
- Nasal congestion
- Hearing
- Vision Loss

Cardiovascular

- Heart or chest pain
- Abnormal heartbeat
- Poor heart function

Lung

- Cough
- Shortness of breath
- Sleep apnea

Gastrointestinal

- Nausea or vomiting
- Stomach pain or ulcers
- Heartburn
- Diarrhea
- Constipation
- Blood in stool

Neurological

- Seizures
- Blackouts/fainting
- Tremor
- Headaches/Migraines
- Difficulty with balance

Genital-Urinary

- Burning with urination
- Urinary incontinence
- Urinary frequency
- Pelvic pain

Hematological

- Excessive bleeding
- Difficulty stopping bleeding

Musculoskeletal

- Joint swelling
- Joint pain
- Muscle aches

Integumentary (Skin)

- Frequent rashes
- Frequent itching
- Easy bruising

Psychiatric

- Depression
- Stress

Additional comments:

X

Signature of patient, parent, or guardian

Date

X

Physician's signature

Date