ORTHOPEDIC GROUP OF BIRMINGHAM, P.C.
HEALTH HISTORY

Name: _____ Age _____ Family Physician / OBGYN_____

Were you referred by a Physician: Y __ N__ Who requested our services? _____

Reason for seeking medical attention: _____ Right Left Both

Are you right or left handed? Right Left Are you pregnant? Y___ N___

Date of injury or duration of symptoms _____ Where did accident/injury happen? _____

Have you seen anyone else regarding this condition? Y__ N__ If yes, list names and dates _____

Have you had any diagnostic studies for this condition such as MRI, Bone Scan, etc? Please List _____

Work Related? __Y __N Automobile Accident? __Y __N Is there a claim? __Y __N Other Liability? __Y __N

Have you ever been diagnosed with any of the following medical condition:

	Yes	No		Yes	No		Yes	No
Asthma	___	___	Rheumatoid Disorders	___	___	Osteoarthritis	___	___
Kidney Disease	___	___	Anemia	___	___	Alcoholism	___	___
Sleep Apnea	___	___	Migraines	___	___	Sickle Cell Disease	___	___
Bleeding Tendencies	___	___	Claustrophobic	___	___	Colitis	___	___
Heart Disease	___	___	Diabetes	___	___	Stroke	___	___
Epilepsy	___	___	Goiter	___	___	Stomach Ulcers	___	___
High Blood Pressure	___	___	Lung Disease	___	___	Depression	___	___
Gout	___	___	Nervous System Disorder	___	___	Reflux	___	___
Hepatitis	___	___	Tuberculosis	___	___	Osteoporosis	___	___
Fibromyalgia	___	___	Cancer	___	___	Osteopenia	___	___
Anxiety	___	___	Which Type(s) _____					

Other Medical Conditions: _____

Please list **any** orthopedic surgeries and dates:
_____
_____
_____

Please list **any** other surgeries:
_____
_____
_____

Have you had a **Flu** shot this year? Yes or No Have you had a **Pneumonia** shot and when? _____

Please list all current medications, including Over the Counter, Vitamins, or Herbal Supplements:
_____
_____
_____

Are you allergic to (Check if you are):
Latex __ Penicillin __ Cephalosporin ___ Mycins __ Sulfa __ Tetanus __ Iodine ___ Dyes __ Aspirin __
Codeine __ Morphine __ Adhesive Tape__ Arthritis Medicines ___
Foods: (please list): _____

Do you have any body piercing/tattoos? ___ Yes ___No If yes, where? _____

Do you currently use tobacco: ___ cigarettes ___pipe ___ smokeless amount per day: _____ How many years? _____
Do you drink alcohol: ___beer ___ liquor ___wine amount per day: _____ or per week: _____

What is your current occupation? _____

Has anyone in your immediate family (mom, dad, brother, sister) had: ____Blood Clots ____ Heart Disease ____Cancer
____Diabetes ____Bleeding Problems _____Lung Disease ____ High Blood Pressure _____ Rheumatologic Disorders

If yes to cancer, what type? _____

Have you recently had any of the following problems or symptoms:

	Yes	No		Yes	No		Yes	No
Chest Pain	___	___	Irregular Heart Beat	___	___	Fainting Spells	___	___
Breathing Difficulties	___	___	Cough	___	___	Cough with Blood	___	___
Numbness or Tingling	___	___	Dizziness	___	___	Headaches or Migraines	___	___
Vision Changes	___	___	Fever or Chills	___	___	Unexpected Weight Loss	___	___
Abdominal Pain	___	___	Nausea or Vomiting	___	___	Diarrhea	___	___
Bloody or Black Tarry Stools	___	___	Loss of Control of Bowels	___	___	Difficulty Starting Urine	___	___
Pain or Burning On Urination	___	___	Blood in Urine	___	___	Loss of Bladder Control	___	___

Patient's Signature: _____ **Physician Signature:** _____
(I have reviewed this information with the patient)

Date: _____

Revised 12/08/2016