Danville Orthopaedics & Sports Medicine Medical History

Name:_____ Referred by: _____

Age: _____ Date: _____

Why are you here today?_____
_____
_____
_____

When did it start?_____

What makes it better? _____What makes it worse? _____

Is your problem the result of (check all that apply):

__Car accident ___Home accident ___Work accident/injury ___Other injury: _____
What treatment have you had?_____

Medical History

List your medical problems (such as diabetes, high blood pressure, heart attack, etc)

_____ _____
_____ _____
_____

Do you take any medications: ___Yes ___ No Height _____ Weight _____

List the medications you currently take:

Medication	Dose/frequency	Medication	Dose/frequency

Are you allergic to any medications? ___Yes ___No

If yes, check choices below:

__ Aspirin __Codeine __Sulfa __Penicillin __Keflex __Latex __Local anesthetic
___Other - please list: _____
For women: Are you taking birth control pills? _____Are you pregnant?_____

Surgical History

Have you ever had surgery? ___Yes ___No

Type of Surgery	Year	Type of Surgery	Year

If you have had surgery, have you ever had problems with anesthesia? ___ Yes ___No

Please complete both sides of this form.

For office use only: (Reviewed by: _____ Date: _____**)**

Family History

	Alive	Deceased	Age	Health status/cause of death
Father	A	D	____	_____
Mother	A	D	____	_____
Sister/Brother	A	D	____	_____
Sister/Brother	A	D	____	_____
Sister/Brother	A	D	____	_____

Social History

Marital status: ___Married ___Separated ___Divorced ___Single ___Widowed
Work status: ___Full-time ___Part-time ___Disabled ___Retired
Occupation: _____ Employed by:_____
Do you smoke currently? ___ Yes ____No _____packs per day for____years
Have you quit smoking? ___This year ___>1 year ___ >5 years ___>10 years
Previously smoked___ packs per day for___ years
Do you drink alcohol ___ Daily ___1-2 times/week ___ never How much?_____

Review of Systems:

Please check below those areas in which you have had medical problems. If you have had no significant medical problems, check here: **None**

Check if Applicable

Constitutional
- O fatigue
- O fever
- O night sweats
- O weight gain (unintentional)
- O weight loss (unintentional)

Eyes
- O blurred vision
- O eye pain
- O glasses/contacts

Ears/Nose/Throat
- O ear pain
- O hearing problems
- O nasal congestion
- O bleeding gums
- O dentures present
- O hoarseness
- O tooth pain

Cardiovascular
- O chest pain
- O pain in legs while walking
- O shortness of breath when laying flat
- O palpitations, irregular heartbeat
- O rapid irregular heart rate
- O venous blood clots

Respiratory
- O cough (chronic)
- O shortness of breath
- O sharp chest pain with breathing
- O wheezing

Gastrointestinal
- O abdominal pain
- O acid reflux
- O loss of appetite
- O difficulty swallowing
- O constipation, diarrhea
- O heartburn
- O nausea or vomiting

Genitourinary
- O pain with urination
- O blood in urine
- O hx frequent UTI's
- O frequency of urination at night
- O excessive urination
- O urinary incontinence

Musculoskeletal
- O joint aches, pains, stiffness
- O back pain
- O muscle aches and pain

Infections
- O History of MRSA (staph infection)

Skin/Breast
- O worrisome skin lesion
- O acne or pimples
- O rashes
- O breast mass
- O nipple discharge

Neurological
- O fainting, dizziness
- O headaches
- O seizures
- O tremor
- O vertigo (spinning dizziness)

Hematological
- O excessive bleeding
- O hx of blood transfusion

Endocrine
- O heat/cold intolerance
- O excessive hair growth or loss
- O excessive thirst

Allergic/Immunologic
- O seasonal allergies/"hay fever"
- O hives with medicine

Psychiatric
- O depression, anxiety
- O excessive mood swings
- O sleep disturbance

What else should we know about your medical condition?_____

Thank you for providing this important information for us.

For office use only: (Reviewed by: _____ Date: _____**)**

(Rev. 3/25/08)