Date: _____ **Medical History** **DOB: _____**

1. Name: _____ Age _____ ☐Right handed ☐ Left handed

2. Occupation: _____

3. Describe problem (be specific): _____

4. Duration of symptoms: _____

5. Date of Injury: _____ Work Injury: ☐No ☐Yes Dates you have been off work: _____

6. Side: ☐ Right ☐ Left ☐ Both

7. Family Physician's Name and location: _____ Referred by: _____

8. List ALL allergies (medication, food, etc.): _____

9. Have you tried ☐ Physical Therapy ☐Braces ☐Shots

10. Have you tried over the counter medicine for this problem? ☐Tylenol ☐Aleve ☐Advil/Motrin (Ibuprofen)

11. Current Medications **Name, Dose, and Frequency** (list all medications taken for any reason – not just for your orthopedic problem)
(if you have a medications/surgeries list with you, you may ask the staff to make a copy instead of filling in the blanks below)

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

12. List all previous **Surgeries and Date of Procedure** (Orthopedic or otherwise):

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

13. Medical problems (check all that you have now or have had in the past)

___ Arthritis
___ Asthma
___ Bleeding Disorder
___ Blood Clots(DVT/PE)
___ Cancer
(type of cancer)
_____
___ Heart Failure (CHF)
___ Depression
___ Diabetes
___ Emphysema/COPD
___ Fibromyalgia
___ Gout
___ Heart Attack/Chest Pain/Angina
___ Cardiac Stents
___ Pacemaker
___ Cardiac Bypass surgery
___ High Blood Pressure (HTN)
___ High Cholesterol
___ HIV/AIDS
___ Kidney Disease or Kidney Failure
___ Dialysis
___ Ulcers
___ Osteoporosis
___ Liver Disease
___ Hepatitis (A, B, or C)
___ Multiple Sclerosis
___ Seizures
___Stroke or Mini/Stroke
___Thyroid Problems
___GERD/Reflux

Other problems not listed above: _____

14. **Health Habits** Do you smoke: ☐ No ☐Yes ☐Former Amount _____

Drink Alcohol: ☐ No ☐Yes Frequency _____ Other Drugs (list): _____

15. **Family History** Please list the problems (from the list above) that run in your immediate family (parents or siblings)

_____

16. **Symptoms** (Please check symptoms you currently have or have had in the past 6 months)

General ___ Fever
___ Chills
___ Sweats at Night
___ Unexplained Weight Loss
Skeletal ___ Joint Pain
___ Weakness
___ Joint Stiffness
GI ___ Nausea
___ Vomiting
___ Diarrhea
___ Blood in Stool
GU ___ Frequent Urination
___ Blood in Urine
___ Pain with Urination
ENT ___ Hearing Loss
___ Sinus Problems
___ Rash
___ Hives
___ Easy Bruising
Eyes ___ Blurred Vision
___ Poor Vision
CV ___ Chest Pain
___ Palpitations
___ High Blood Pressure
Neuro ___ Headaches
___ Numbness/Tingling
Resp ___ Shortness of Breath
___ Persistent Cough