

ORTHOPEDIC SPECIALISTS, P.C.
MEDICAL HISTORY QUESTIONNAIRE
Mark B. Wagner, M.D.

Patient Name: _____ Date of appointment: _____

Address: _____ Age: _____ Sex: M F

Phone: Home: (_____) _____

Work: (_____) _____

Referred by: Self Family Doctor Other _____

Name of your primary physician: _____ Phone: (_____) _____

Primary reason for this appointment: _____

Describe briefly your present symptoms: _____

Date symptoms began (approximate): _____

Is problem due to on-the-job injury? No Yes Date of injury: _____

Employer: _____ Occupation: _____

Number of hours worked / average per week: _____ Year retired (if retired) _____

Previous treatment and response for this problem: _____

Please circle corresponding pain number:

How intense is the pain?	No Pain	0	1	2	3	4	5	6	7	8	9	10	Severe Pain
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(location: _____) (frequency: _____)

PAST MEDICAL HISTORY:

Significant illness in the past: (diabetes, high blood pressure, etc.): _____

SOCIAL HISTORY:	PREVIOUS OPERATIONS:
1. Do you live in your own home or apartment? _____	TYPE YEAR SURGEON CITY
2. Occupation _____	1. _____
3. Tobacco <input type="checkbox"/> Yes <input type="checkbox"/> No pks/day _____ quit? _____	2. _____
4. Alcohol <input type="checkbox"/> Yes <input type="checkbox"/> No gl/day _____ gl/wk _____	3. _____
5. Hobbies/Interests? _____	4. _____
_____	5. _____
_____	6. _____
_____	7. _____
_____	8. _____

Any previous fractures? No Yes Describe: _____

Any other serious injuries? No Yes Describe: _____

HISTORY:

1. Any medical conditions that seem to run in your family? _____
2. Any history of blood clots or bleeding problems? _____
3. Do you live in your own home or apartment? _____
4. If you were to need an operation, do you have help in your home? _____
5. Is transportation a problem to you? _____

MEDICATIONS:

Drug Allergies: No Yes To what? _____

Type of reaction? _____

Are you allergic to Latex? No Yes

Present: (List any medications that you are taking at this time, include such items as aspirin, vitamins, laxatives, calcium supplements, etc.)

Name of Drug	Dose: Include strength and # of pills per day	How long have you taken this medication?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

DO YOU HAVE OR HAVE YOU EVER HAD:

(Circle those that apply and write in others)	YES	NO
Eye, ear, nose, throat problems: (glaucoma: lens implants; dentures; difficulty hearing; wear hearing aids, glasses or contacts)	<input type="checkbox"/>	<input type="checkbox"/>
Heart problems: (chest pain, angina, heart attack, congestive heart failure, irregular heart beats, pacemaker)	<input type="checkbox"/>	<input type="checkbox"/>
Vascular problems: (high blood pressure, blood clots)	<input type="checkbox"/>	<input type="checkbox"/>
Lung Problems: (asthma, emphysema, tuberculosis, coughing, coughing blood, abnormal chest x-ray, sleep apnea)	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal problems: (hepatitis, cirrhosis, ulcers, reflux, hiatal hernia, intestinal bleeding, heartburn)	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary problems: (OB/GYN, kidney disease/failure, prostate problems, incontinence, sexually trans. diseases, infections)	<input type="checkbox"/>	<input type="checkbox"/>
Is there any possibility you could be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Musculoskeletal problems: (back problems, broken bones, gout, limited range of motion, arthritis, TMJ)	<input type="checkbox"/>	<input type="checkbox"/>
Skin problems: (rash, hives, bruise easily, open sores)	<input type="checkbox"/>	<input type="checkbox"/>
Neurological problems: (seizures, paralysis/numb areas, stroke, weakness, migraines, confusion, dizziness)	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric Care: (anxiety, depression, bipolar disorder)	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine problems: (diabetes, thyroid, weight gain/loss) If diabetic, controlled by: diet oral agent insulin	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disorders: Anemia / Unusual bleeding problems /HIV	<input type="checkbox"/>	<input type="checkbox"/>
Cancer:	<input type="checkbox"/>	<input type="checkbox"/>
A bad reaction to anesthesia? Describe:	<input type="checkbox"/>	<input type="checkbox"/>
A religious objection to blood transfusion?	<input type="checkbox"/>	<input type="checkbox"/>
Living will?	<input type="checkbox"/>	<input type="checkbox"/>
Advance Directive?	<input type="checkbox"/>	<input type="checkbox"/>

_____ PATIENT SIGNATURE		HISTORY REVIEWED:	
		_____ DATE	_____ INITIALS
_____ DATE		_____ PHYSICIAN SIGNATURE	