ORTHOPEDIC SPECIALISTS, P.C.

MEDICAL HISTORY QUESTIONNAIRE

PATIENT NAME: ❑ M ❑ F

DATE OF BIRTH: **AGE:**

PRIMARY CARE DOCTOR & DR.'S TELEPHONE #

OCCUPATION:

WHY ARE YOU HERE?

TREATMENT BEFORE ARRIVAL?

ALLERGIES TO MEDICINE? ❑ YES ❑ NO

If yes, list:

MEDICATION ❑ NONE

DOSE / FREQUENCY

DO YOU USE:

ASPIRIN ❑ YES ❑ NO

TOBACCO ❑ YES ❑ NO PPD___ QUIT?

ALCOHOL ❑ YES ❑ NO GL/DAY___ GL/WK___

RECREATIONAL DRUGS: ❑ YES ❑ NO

If yes, list:

SURGERIES, HOSPITALIZATIONS, BIRTHS OR ILLNESSES:

(Include Dates)

INJURIES: (Indicate if on-the-job)

FAMILY HISTORY: (Cancer, Stroke, Heart Disease)

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)	❑	❑
Heart problems: (chest pain, angina, heart attack, congestive heart failure, irregular heart beats, pacemaker)	❑	❑
Vascular problems: (high blood pressure, blood clots)	❑	❑
Lung Problems: (asthma, emphysema, tuberculosis, coughing, coughing blood, abnormal chest x-ray, sleep apnea)	❑	❑
Gastrointestinal problems: (hepatitis, cirrhosis, ulcers, reflux, hiatal hernia, intestinal bleeding, heartburn)	❑	❑
Genitourinary problems: (OB/GYN, kidney disease/failure, prostate problems, incontinence, sexually transmitted diseases, infections)	❑	❑
Is there any possibility you could be pregnant?	❑	❑
Musculoskeletal problems: (back problems, broken bones, gout, limited range of motion, arthritis, TMJ)	❑	❑
Skin problems: (rash, hives, bruise easily, open sores)	❑	❑
Neurological problems: (seizures, paralysis/numb areas, stroke, weakness, migraines, confusion, dizziness)	❑	❑
Psychiatric Care: (anxiety, depression, bipolar disorder)	❑	❑
Endocrine problems: (diabetes, thyroid, weight gain/loss) If diabetic, controlled by: diet oral agent insulin	❑	❑
Blood Disorders: Anemia / Unusual bleeding problems / HIV	❑	❑
Cancer:	❑	❑
A bad reaction to anesthesia? Describe:	❑	❑
A religious objection to blood transfusion?	❑	❑
Living will?	❑	❑
Advance Directive?	❑	❑

PATIENT SIGNATURE _____ DATE _____

HISTORY REVIEWED:

DATE _____ INITIALS _____ DATE _____ PHYSICIAN SIGNATURE _____