THE ORTHOPEDIC SPECIALTY CLINIC at TOSH

PATIENT MEDICAL HISTORY

Occupation _____Age_____ Height_____ Weight_____
Referring Physician_____ Date of Birth_____

Chief Complaint/History of Present illness

Date of injury or onset of symptoms _____
Are you still working despite your illness/injury? _____
Which body part is involved? _____
List activities which cause pain _____
Rate the pain (Please circle 0=no pain; 10=most severe)
0 1 2 3 4 5 6 7 8 9 10
What activities/medications help your condition? _____
_____
What previous treatment have you had for this problem? _____
_____
Are you right or left hand dominant? _____

I have reviewed this patient's medical history sheet as they have recorded it.

Signed:

_____
Provider Signature

_____
Date

Medical History – Please check any of the following that you have had:

____ Diabetes: Type 1 or 2
____ Thyroid Problems
____ Heart Problems
____ Blood Clots
____ High Blood Pressure
____ Stroke
____ Seizures
____ Asthma
____ Tuberculosis (TB)
____ Liver Problems
____ Elevated Cholesterol
____ Kidney, Bladder or Prostate problems
____ Stomach Ulcer or Reflux Problems
____ Difficulty Opening Mouth
____ Muscle Disorders
____ Mental Health Disorders
____ Skin Disorders
____ Sleep Apnea
____ Severe/Migraine Headaches
____ Arthritis RA OA
____ Cancer-Type/Location_____
_____

Other serious health conditions _____

Surgical History – Please list any previous surgeries that you have had:

Surgery	Date	Physician	Hospital	City/State

Current Medications – Please list all medications you are currently taking:

Medication	Dosage (mg, mcg, etc.)	Frequency (times per day, etc.)

Allergies

Are you allergic to latex? ☐Yes ☐No Are you allergic to any medication? ☐Yes ☐No
If YES, list medication and reaction _____
List any other allergies _____

Social History

Do you use tobacco? ☐Yes ☐No Form of tobacco _____
Frequency of daily use (e.g., 2 packs a day) _____
Do you drink alcoholic beverages? ☐Yes ☐No Average number of drinks per week _____
Do you have a history of substance abuse? ☐Yes ☐No

Family History – Has or does anyone in your family have any of the following?

Heart Trouble	☐Yes ☐No	Relationship _____
Diabetes	☐Yes ☐No	Relationship _____
Tuberculosis	☐Yes ☐No	Relationship _____
High Blood Pressure	☐Yes ☐No	Relationship _____
Pneumonia	☐Yes ☐No	Relationship _____
Cancer	☐Yes ☐No	Relationship _____
Sudden Death	☐Yes ☐No	Relationship & Cause _____
Arthritis	☐Yes ☐No	Relationship _____

Review of Sytems

Musculoskeletal

Do you have any chronic or intermittent back pain? ☐Yes ☐No

Do you have problems with any other joints such as pain, swelling, stiffness or weakness? ☐Yes ☐No

If YES, please explain _____

Skin

Do you have any rashes, lesions, lumps, or sores? ☐Yes ☐No

If YES, please explain _____

Neurological

Do you have a history of seizures or other nervous system disorders requiring medications? ☐Yes ☐No

If YES, please explain _____

Do you have any previous history of stroke? ☐Yes ☐No

Do you have any problems with headaches or dizziness? ☐Yes ☐No

Psychiatric

Do you have a drug or alcohol addiction? ☐Yes ☐No

Do you have any problems with depression? ☐Yes ☐No

Endocrine

Do you have any problems with excessive thirst or intolerance to heat or cold? ☐Yes ☐No

Hematology

Do you have any problems with easy bleeding? ☐Yes ☐No

Do you have any problems with easy bruising? ☐Yes ☐No

Do you have any problems with anemia? ☐Yes ☐No

Have you ever had a blood clot? ☐Yes ☐No

Constitutional

Have you had any recent coughs or colds? ☐Yes ☐No

Eyes

Do you have any tearing, eye pain, pressure, or changes in vision? ☐Yes ☐No

If YES, please explain _____

Ear, Nose and Throat

Do you have a sore throat? ☐Yes ☐No

Do you have difficulty hearing? ☐Yes ☐No

Cardiovascular

Do you have chest or arm pain on exertion? ☐Yes ☐No

Do you have a chronic cough either dry or with blood or sputum? ☐Yes ☐No

Gastrointestinal

Do you have gastritis? ☐Yes ☐No

Do you have colitis? ☐Yes ☐No

Do you have diverticulitis? ☐Yes ☐No

Do you have hepatitis? ☐Yes ☐No

Genitourinary

Do you have prostate trouble? ☐Yes ☐No

Do you have to get up at night to urinate? ☐Yes ☐No

Do you have frequency of urination? ☐Yes ☐No

Other Considerations

Do you have vision or hearing disabilities? ☐Yes ☐No Please specify _____

Do you have any physical limitations? ☐Yes ☐No Please specify _____

Is there anything else we should know about you? _____

Patient Signature	Date / /