Medical History

Date of Birth: _____ Today's Date: _____

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	___Diabetes	___High Blood Pressure (HTN)	___Liver Disease
___Asthma	___Emphysema/COPD	___High Cholesterol	___Hepatitis (A, B, or C)
___Bleeding Disorder	___Fibromyalgia	___HIV/AIDS	___Multiple Sclerosis
___Blood Clots(DVT/PE)	___Gout	___Kidney Disease or	___Seizures
___Cancer	___Heart Attack/Chest	Kidney Failure	___Stroke or Mini/Stroke
(type of cancer)	Pain/Angina	___Dialysis	___Thyroid Problems
_____	___Cardiac Stents	___Ulcers	___GERD/Reflux
___Heart Failure (CHF)	___Pacemaker	___Osteoporosis	
___Depression	___Cardiac Bypass surgery		

Other problems not listed above: _____

14. **Health Habits** Do you smoke: ☐ No ☐Yes ☐Former Amount _____ Nicotine use (Circle): Vape / Dip snuff / gum / patches
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)

_____