orthopaedicseast
& SPORTS MEDICINE CENTER

Patient Medical History Form

Patient Name ______________________
Account Number (For Office Use) ______________________
Date of Birth ______________________
Height ______________________
Weight ______________________

Primary Insurance ______________________
Secondary Insurance ______________________

What Body site(s) are you being evaluated for today? ______________________

Location ☐ RT ☐ LT ☐ Both Sides

Date Problem or Injury Began? _____ / _____ / _____

Referring Provider ______________________
Phone Number ______________________
Address ______________________
____

Primary Care Provider ______________________
Phone Number ______________________
Address ______________________
____

Pharmacy Name ______________________
Phone Number ______________________
Address ______________________
____

If Due To Injury, What Type Of Injury? ______________________

How Did The Injury Occur ? ______________________

Type of Symptoms:

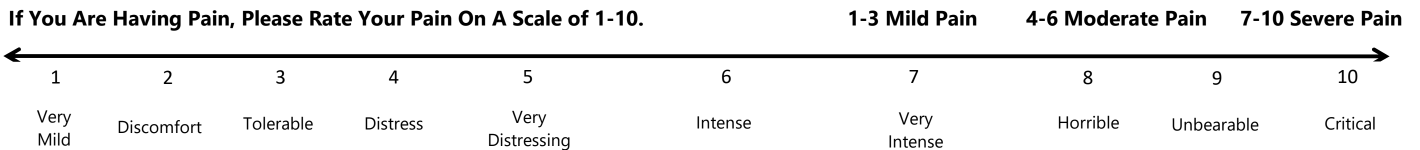
☐ Joint Pain ☐ Muscle Pain ☐ Weakness ☐ Stiffness ☐ Swelling ☐ Tingling ☐ Instability ☐ Catching ☐ Grinding ☐ Limb Pain

☐ Other, Please Explain ______________________

If You Are Having Pain, What Type of Pain?

☐ Aching ☐ Sharp ☐ Shooting ☐ Dull ☐ Tender ☐ Mild ☐ Other ______________________

If You Are Having Pain, Please Rate Your Pain On A Scale of 1-10. **1-3 Mild Pain** **4-6 Moderate Pain** **7-10 Severe Pain**



When Do You Have The Above Symptom(s)?

☐ All the Time ☐ In the Morning ☐ In the Evening ☐ At Rest ☐ During Activity ☐ After Activity ☐ Other ______________________

What Makes Your Symptom(s) Better?

☐ Ice ☐ Rest ☐ Heat ☐ Nothing ☐ Medication (Type) ____________ ☐ Other ______________________

Medications: Please Include All Prescriptions, Over The Counter, Vitamins, and Supplements.

Medication/Vitamin/Supplement Name:	Dosage	Times per Day

Allergies: Please List All Allergies to Medications

Medication Allergy	Reaction	How Was It Treated?

Review Of Systems: Are You Currently Experiencing Any Of The Following? Check All With The Response Of " Yes" or Not Applicable (N/A)

Constituonal	Musculoskeletal	Endocrine	Allergies	Integumentary	Neurological	Psychological
❑ **N/A** ❑ Weight Loss/Gain ❑ Fever ❑ Chills ❑ Loss of Appetite	❑ **N/A** ❑ Joint pain ❑ Muscle pain ❑ Stiffness Joints ❑ Swelling Joints	❑ **N/A** ❑ Fatigue ❑ Weakness ❑ Extreme Thirst	❑ **N/A** ❑ Metal ❑ Latex ❑ Other List____________ _____________	❑ **N/A** ❑ Skin Rash ❑ Itching ❑ Skin Lesion ❑ Sores	❑ **N/A** ❑ Weakness ❑ Numbness ❑ Tingling	❑ **N/A** ❑ Depression ❑ Anxiety ❑ Memory Loss
Hematology	**Cardiovaccular**	**ENT**	**Eyes**	**GU**	**Respiratory**	**GI**
❑ **N/A** ❑ Bleeding Tendencies ❑ Easy Bruising ❑ Blood Clotting	❑ **N/A** ❑ Swelling of Feet, Ankles or Legs ❑ Heart failure ❑ Chest Pain	❑ **N/A** ❑ Hearing Loss ❑ Ringing in Ears	❑ **N/A** ❑ Loss of Vision ❑ Blurry Vision	❑ **N/A** ❑ Kidney Infection ❑ UTI	❑ **N/A** ❑ Shortness of Breath ❑ Prolonged Cough ❑ Asthma	❑ **N/A** ❑ Abdominal Pain ❑ Nausea ❑ Vomiting

Are you currently pregnant? __________(Yes, No, N/A)

Past History: Have You Been Treated For Any Of The Following? Check All With The Response Of "Yes"

☐ Aids/HIV ☐ Alzheimers ☐ Anemia ☐ Arthritis ☐ Asthma ☐ Autoimmune Problem ☐ Blood Clot/Clotting Disorder ☐ Congestive Heart Failure
☐ COPD ☐ Depression ☐ Diabetes Type _______ ☐ Fibromyalgia ☐ Heart Attack/Heart Disease ☐ Hepatitis ☐ High Blood Pressure
☐ High Cholesteral ☐ Gout ☐ Kidney Disease ☐ Liver Disease ☐ Parkinsons ☐ Pulmonary ☐ Seizures ☐ Sickle Cell
☐ Sleep Apnea ☐ Stroke ☐ Thyrold Disease ☐ Other ____

Family History: Please Check All That Apply	Mother	Father	Sibling	Child
Osteoarthritis	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
Musculoskeletal Complaints	☐	☐	☐	☐
Blood/Clotting Disorders	☐	☐	☐	☐

Social History: Please Check All That Apply

Smoking ☐ Yes ☐ No If Yes, Packs per Day? _________________ Number of Years? _____________________
Alcohol Use ☐ Yes ☐ No If Yes, Drinks per Day? _________________ Number of Years? _____________________
Substance/IV Drug Use ☐ Yes ☐ No If Yes, Please Specify Drug and Usage ____
Are you currently pregnant? ☐ Yes ☐ No If Yes, Number of Weeks ____
Employment Status ☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled

Surgical History: List Any Major Surgical Procedures And Date Below

Surgical Procedure(s) Date

____

____

Any Prior Complications with Anesthesia? ☐ Yes ☐ No If Yes, Please Explain ____

I Attest To The Best Of My Knowledge That The Above Information Is Accurate

Patient/Guardian Authorized Signature ____ **Date ___ / ___ /___**

Reviewed By Provider : ____ **Date ___ / ___ / ___**