UNIVERSITY ORTHOPAEDIC ASSOCIATES, LLC

Medical History Form- please complete and circle all that apply

Patient Name:______________________ **DOB:**_____________ **DATE:.** _____________

1. Name of Physician Seeing Today: ________________________________

2. Type of Problem/Accident: Work Accident Auto Sport Chronic Fall Not injury related Other

3. Body Part Injured or Symptomatic: ____________ **4. Side of Body:** Right Left Bilateral

5. Injury Date if Applicable: ____________ **6. Specialized Appt**: Consultation 2nd Opinion IME

7. Brief Description of Problem/Accident/Injury/: (This is a necessary part of medical record please be as detailed as possible)

____

8. How were you referred to this office?____

9. Where did your injury occur: Work Home Store Street Park School Other: _____________

10. Where you seen in the emergency room? Yes No If yes; which hospital? _____________

11. Current Symptoms: Pain Swelling Stiffness Numbness Weakness Mass/lump Black &Blue

12. How long have you had these symptoms? ________________________________

13. Diagnostic treatments: X-rays MRI Blood Work Other Outside physician, name: _____________

14. Please rate the severity of your symptoms: (1 minimal, 10 severe) 1 2 3 4 5 6 7 8 9 10

Review of Systems/Medical History (If you have **chronic or previous history**, please circle No or Yes and explain)

Cardiovascular:

1. Arrhythmia No Yes, explain:________________________________
2. Heart Attack No Yes, explain:________________________________
3. Heart Disease No Yes, explain:________________________________
4. High Cholesterol No Yes, explain:________________________________
5. High Blood Pressure No Yes, explain:________________________________
6. Stroke No Yes, explain:________________________________

Respiratory:

7. Asthma No Yes, explain:________________________________

Circulatory:

8. Bleeding No Yes, explain:________________________________
9. Blood clot No Yes, explain:________________________________

Immune:

10. Cancer No Yes, explain:________________________________

Skeletal:

11. Arthritis No Yes, explain:________________________________

12. **Have you had a Dexa Scan? No Yes When?** ________________________

Integumentary:

12. Skin Disease No Yes, explain:________________________________

Endocrine:

13. Thyroid No Yes, explain:________________________________
14. Diabetes No Yes, type: _____I _____ II ______ diet controlled duration: ______________

Renal:

15. Kidney No Yes, explain:________________________________

Nervous:

16. Seizures No Yes; explain:________________________________

Reproductive No Yes; explain:________________________________

Digestive No Yes; explain:________________________________

Reviewed by____________**MD Date:**_________ **Please turn, complete, & sign**

Social History

Age:___________ **Occupation**:____

Height:_________ Weight:______________ Do you drink alcohol? No Minimal Moderate Heavy

Do you smoke? No Yes _________Packs per day For______ years smoked previously_____ duration________________________

Marital Status: ___ Married ____ Single ___ Divorced ___Widowed **Living Conditions**: ___ Spouse ___ Family Member ___ Assisted Living Alone

* **MEDICAL DOCTOR***:

What is the name of your current medical doctor:______________________________ **Phone Number**__________________________

SURGICAL PROCEDURES:
Please list all of your surgeries and the year they were performed

____

____

____

ORTHOPAEDIC PROCEDURES:
Please list all of your surgeries, the year they were performed, and please list the surgeon: ____

____

____

MEDICATIONS: **(For us to safely prescribe you medication; we require that you provide us with a current list)**

Are you currently taking any medications? _____ No _______ **Yes; PLEASE LIST ALL MEDS**:____

____

____

PREFERRED PHARMACY ____

Name Address City State Telephone

ALLERGIES:

Do you have any drug allergies? _______ No _______Yes; list:____

Family History

Have any of your family members had problems with: (Please circle No or Yes and explain your Yes answers)

Arthritis	No	Yes, explain:____
Cancer	No	Yes, explain:____
Diabetes	No	Yes, explain:____
High Blood Pressure	No	Yes, explain:____
Heart Disease	No	Yes, explain:____
Other	No	Yes, explain:____

I have completed this form & carefully reviewed its contents. I attest to the accuracy & correctness of the information

____________________________________ ______________________________

Patient or Guardian Signature Date