

NORTHTOWNS ORTHOPEDICS, P.C.
MEDICAL HISTORY

Date: _____

Name: _____ Birthdate: _____ Age: _____ Sex M F

Primary Care Doctor: _____

Chief Complaint:

Why are you seeing the Doctor today? _____

History of present Illness:

When did your present condition begin? _____

Current Problem is a result of (an) Check all that apply

- Car Accident Work Related Accident/Injury Other Accident Sports Related
 Other _____

I was doing the following when the condition began: Check all that apply

- Lifting Pulling Pushing Twisting Falling Bending Reaching
 Squatting Sports Suddenly Gradually Hit by Object Not Known

Current Medications:

Medication	Dose	How Long?

Allergies:

Are you allergic to any medications? Yes No If yes Please List _____

Are you allergic to Latex? Yes No

Review of Systems:

Are you currently having or have you had problems with: Check all that apply

- Fever/Chills/Night Sweats High Blood Pressure Arthritis
 Eyes Heart Disease Polio
 Ears, Nose Throat Balance Problems TB
 Lungs, Breathing Numbness/tingling Epilepsy/Seizures
 Digestion Weakness Are you Pregnant Yes No
 Gastritis/Ulcers Blackout/Fainting Bleeding Problems
 Bowel movements Psychologic Problems Blood Transfusions Yes No
 Bladder Problems Diabetes Cancer

Briefly describe any items checked: _____

Reviewed by: _____ M.D. Date: _____

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Date: _____

Name: _____

Past Medical History:

Surgeries / Hospitalizations	Year
Illnesses/Injuries not described?	

Have you ever had general anesthesia? Yes No

If yes, have you had any problems with anesthesia? Yes No Describe: _____

Family History:

Member	Alive/Deceased	Age	Health Status or Cause of Death
Father	A / D		
Mother	A / D		
Sister/Brother	A / D		
Sister/Brother	A / D		

Do you have a family history of bleeding problems? Yes No

Do you have a family history of anesthetic problems? Yes No

Social History:

Work at Home Employed (Occupation) _____ Student

Are you working now? Yes No Last Date Worked _____

Full Time Part Time Retired Unemployed

Disabled: Total Partial Workers Compensation Disability Policy

Are you off work due to this problem? Yes No

Are you off work due to another problem? Yes No

Have you lost time previously due to this injury? Yes No

Children? Yes No # _____

Do you live alone? Yes No

Are you on a special diet? Yes No Describe: _____

Do you have a history of substance abuse? Yes No Substance: _____

Do you currently smoke? Yes No _____ Packs per day for _____ years

Have you quit smoking? Yes No This year > 1 year > 5 years > 10 years

Previously smoked _____ Packs per day for _____ years

Do you drink alcohol? Yes No Daily 1 – 2 x per week 1 – 2 x per month More

Highest level of Education reached Finished High School Some College Finished College _____
 Graduate Degree Other

Reviewed by: _____ M.D.

Date: _____