

ORTHOPAEDIC MEDICAL GROUP

PATIENT MEDICAL HISTORY FORM

DATE _____

NAME _____

REVIEW OF SYSTEMS:

(PLEASE CHECK ALL THAT APPLY)

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Bowel irregularity | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Rashes |
| <input type="checkbox"/> Sore throat | <input type="checkbox"/> Dizziness/fainting | <input type="checkbox"/> Frequent infections | <input type="checkbox"/> Swollen glands |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Fever | <input type="checkbox"/> Joint pain/swelling | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Shaking/chills | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Numbness/tingling | <input type="checkbox"/> Weight loss |

PAST MEDICAL HISTORY:

(PLEASE CHECK ALL THAT APPLY)

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Vascular disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> G.I. disorder | <input type="checkbox"/> Neurological disorder | <input type="checkbox"/> Menstrual dysfunction |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Anemia | <input type="checkbox"/> Seizures | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Gallbladder disease | <input type="checkbox"/> Gout | <input type="checkbox"/> Other |
| <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Angina | | |

PLEASE FILL IN ANY OTHER INFORMATION YOU FEEL IS IMPORTANT:

PAST SURGICAL HISTORY/HOSPITALIZATIONS

Reason

Dates

FAMILY HISTORY

Father

Mother

Grandparents

Siblings

Hearth disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HABITS

SMOKE: Packs daily _____ How long? _____

ALCOHOL: Type _____ Amount _____

EXERICISE? _____

WOMEN

PREGNANT? YES NO PLANNING PREGNANCY? YES NO

CURRENT MEDICATIONS

DRUG ALLERGIES
