Orthopaedics of Brevard - Patient's Medical History

Name: _____ DOB: _____ Date: _____

Age: ____ Gender: ____ Accompanied By Today: _____ Are you? ❑ Left-Handed ❑ Right-Handed

Primary Care Physician: _____ Referred by: _____

Pharmacy: _____ Location: _____ Phone: _____

Date of Injury/Onset: _____ Location/Area of Concern: _____

Studies Performed: ❑ X-ray ❑ MRI ❑ CT ❑ Nerve Conduction Study Where: _____

Previous Treatment: ❑ Orthotic Support ❑ Ice/Heat ❑ Cortisone Injection ❑ Anti-Inflammatories ❑ Therapy

Injury Details (specify): _____

Allergies to Medications: ❑ No Known Medication Allergies

Name of Medication	Reaction	Level of Severity
_____	_____	❑ Mild ❑ Moderate ❑ Severe
_____	_____	❑ Mild ❑ Moderate ❑ Severe
_____	_____	❑ Mild ❑ Moderate ❑ Severe

Current Medications: ❑ Not currently taking any medications

Medication	Reason Prescribed	Medication	Reason Prescribed
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Past Medical History: ❑ No past medical problems

Medical Problem	Medical Problem
_____	_____
_____	_____
_____	_____
_____	_____

Surgical History: ❑ Never had surgery

Surgical Procedure - indicate Left or Right please	Surgical Procedure - indicate Left or Right please
_____	_____
_____	_____
_____	_____
_____	_____

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Name: _____ DOB: _____ Date: _____

Family Medical History: ❑ No past medical history

Please check condition that your **Mother (M), Father (F**) or **Grandparents (G)** have or had:

Cardiac Disease: ❑ M ❑ F ❑ G	Cancer: ❑ M ❑ F ❑ G	Diabetes: ❑ M ❑ F ❑ G
High Blood Pressure: ❑ M ❑ F ❑ G	Blood Clots (DVT): ❑ M ❑ F ❑ G	Scoliosis: ❑ M ❑ F ❑ G
Anesthesia Problems: ❑ M ❑ F ❑ G	Kidney Problems: ❑ M ❑ F ❑ G	Osteoporosis: ❑ M ❑ F ❑ G
Bleeding Disorder: ❑ M ❑ F ❑ G	Stroke: ❑ M ❑ F ❑ G	Arthritis: ❑ M ❑ F ❑ G

Social History:

Occupation: _____ ❑ Full-time ❑ Part-time ❑ Student ❑ Retired

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed Do you live alone: ❑ Yes ❑ No

Tobacco Use: ❑ Never ❑ Current - Packs per day _____ ❑ Quit – Year Quit_____ ❑ Oral Tobacco/Cigars

Alcohol Use: ❑ None ❑ Socially ❑ Occasionally(<6/month) ❑ Moderately(>2/day) ❑ Heavy (>5/day)

Recreational Drug Use: ❑ None ❑ Presently ❑ Past Problem

Review of Systems:

Check **Yes (Y)** or **No (N)** for each symptom below. Please do not leave any blank.

General:		**Skin:**		**Head/Ears/Eyes/Mouth/Throat:**	
Anesthesia Problems:	❑ Y ❑ N	Psoriasis:	❑ Y ❑ N	Dizziness:	❑ Y ❑ N
Chills or Fever:	❑ Y ❑ N	Shingles:	❑ Y ❑ N	Double Vision:	❑ Y ❑ N
Fatigue:	❑ Y ❑ N	Skin Cancer:	❑ Y ❑ N	Headaches:	❑ Y ❑ N
Weight Change:	❑ Y ❑ N	Skin Infection:	❑ Y ❑ N	Hearing Loss:	❑ Y ❑ N
				Nose Bleeds:	❑ Y ❑ N
Gastrointestinal:		**Pulmonary:**			
Abdominal Pain:	❑ Y ❑ N	Asthma:	❑ Y ❑ N	**Urologic:**	
Acid Reflux/GERD:	❑ Y ❑ N	COPD:	❑ Y ❑ N	Dialysis/Kidney Failure:	❑ Y ❑ N
Aspirin/NSAID Intoler:	❑ Y ❑ N	Emphysema:	❑ Y ❑ N	Kidney Stones:	❑ Y ❑ N
Blood in Stool:	❑ Y ❑ N	Sleep Apnea:	❑ Y ❑ N	Incontinence:	❑ Y ❑ N
Hepatitis:	❑ Y ❑ N	Smoker Last 7 Yrs:	❑ Y ❑ N	Prostate Problems:	❑ Y ❑ N
Musculoskeletal:		**Cardiovascular:**		**Endocrine/Immune:**	
Back Pain:	❑ Y ❑ N	Anemia:	❑ Y ❑ N	AIDS/HIV:	❑ Y ❑ N
Bone Deformities:	❑ Y ❑ N	Bleeding Problems:	❑ Y ❑ N	Diabetes:	❑ Y ❑ N
Fibromyalgia:	❑ Y ❑ N	Blood Clots:	❑ Y ❑ N	Gout:	❑ Y ❑ N
Loss of Strength:	❑ Y ❑ N	Cardiac Stents:	❑ Y ❑ N	History of Cancer:	❑ Y ❑ N
Metal in Body:	❑ Y ❑ N	Chest Pain:	❑ Y ❑ N	Poor Healing:	❑ Y ❑ N
Muscle Weakness:	❑ Y ❑ N	High Blood Pressure:	❑ Y ❑ N		
Neck Pain:	❑ Y ❑ N	High Cholesterol:	❑ Y ❑ N	**Psychiatric:**	
Numbness/Tingling:	❑ Y ❑ N	Irregular Heart Beat:	❑ Y ❑ N	Anxiety:	❑ Y ❑ N
Osteoarthritis:	❑ Y ❑ N	Pacemaker:	❑ Y ❑ N	Dementia:	❑ Y ❑ N
Osteoporosis:	❑ Y ❑ N	Shortness of Breath:	❑ Y ❑ N	Depression:	❑ Y ❑ N
Rheumatoid Arthritis:	❑ Y ❑ N	Use of Blood Thinners:	❑ Y ❑ N	Sleep Disorder:	❑ Y ❑ N