Name:
DOB:
Chart:
Age:
Date:

Medical Information Form

This form must be filled out before you see the physician. The information on the form provides basic information about your orthopedic problem and general health condition. This information is very important and can influence your orthopedic diagnosis and treatment.

Today's Date: ____________ Account #: ____________ Imaging: ____________

Name: ____________ Sex: ____________ Date of Birth: ____________ Age: ____________

Referring Doctor: ____________

Height: ________ Weight: ________ Occupation: ____________ Dominant Hand: ☐ Right ☐ Left

What orthopedic problems are you being seen for? ____________

Did your symptoms result from an accident? ☐ Yes ☐ No If "yes" list dates & nature of accident: ____________

If "No" when did your problem first occur? ____________

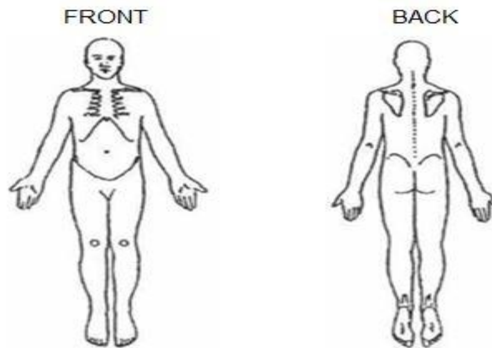
Have you seen a doctor for this problem? ☐ Yes ☐ No If "yes", who? ____________

Where is your problem located? (Right or Left) ____________

Please rate your pain area on Diagram below:

Mark with a:

* "1" for most painful
* "2" for next most painful
* "3" for next most painful



How would you describe your symptoms? (Check all that apply)

☐ Dull Ache ☐ Sharp Ache ☐ Stabbing ☐ Tingling ☐ "Sleepy" ☐ Cramping ☐ Spasms
☐ Stiffness ☐ Popping ☐ Cracking ☐ "Giving Out" ☐ Numb ☐ Cold
☐ Burning ☐ Chills ☐ Weak ☐ Hot

Please check the severity of your symptoms:

☐ Mild- no compromise of activities ☐ Slight- some compromise of activities
☐ Moderate- marked compromise of activities ☐ Severe- unable to perform activities

Has this been improving? ☐ Improving ☐ Getting worse ☐ Staying unchanged

How frequent are the symptoms in this area?

☐ Occasional- less than half the day ☐ Intermittent- about half the day
☐ Frequent- more than half the day ☐ Constant- all day and everyday

What relieves the symptom? ____________

What makes the symptom worse? ____________

Have you had similar problems before? ____________

Name:
DOB:
Chart:
Age:
Date:

What medical tests or treatment have you received for this problem?

☐ X-RAY ☐ CT SCAN ☐ MRI ☐ Bone scan ☐ Blood Tests ☐ Nerve tests (EMG)
☐ Myelogram ☐ Nerve Injection (nerve root block) ☐ Joint Injection ☐ Discogram (X-ray of discs in back)
☐ Other ____________________

List all SURGERIES you have had and approximate date. (Example: Hip replacement 1999)

List all ALLERGIES and your reaction to them:

List all current MEDICATIONS that you take regularly, dosage, and time you take it.

Medicine/Herb	Dosage	Frequency
Example: Motrin	800 mg	1 pill at 8am, 1 pill at 6pm

What ACTIVE medical conditions do you have? (Check all that apply)

☐ Diabetes ☐ Rheumatoid Arthritis ☐ COPD ☐ Sleep Apnea ☐ AFIB ☐ Reflux ☐ Hypertension ☐ Anemia ☐ OTHER: ____________

List any serious past medical conditions you have had.

Other substances:

Substance	Currently Use		Previously Used		How much?	How long?	When Stopped?
Example: Tobacco	☐ Yes	☐ No	☐ Yes	☐ No	1 pack/day	20 years	1982
Caffeine: Coffee, tea, soda	☐ Yes	☐ No	☐ Yes	☐ No			
Tobacco	☐ Yes	☐ No	☐ Yes	☐ No			
Alcohol: beer, wine, liquor	☐ Yes	☐ No	☐ Yes	☐ No			
Recreation/Street drugs	☐ Yes	☐ No	☐ Yes	☐ No			

Family medical history:

Relative	Current age	(or age at death)	Current medical conditions (or cause of death)
Father			
Mother			
Brother/Sister			
Children			

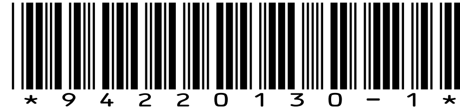
List any hobbies: ____________________

List any exercise program: ____________________

Check any of these NEW problems that apply to you:

☐ Weakness in arms ☐ Weakness in legs ☐ Difficulty with balance ☐ Fevers ☐ Chills ☐ Sweats ☐ Loss of appetite
☐ Unexpected weight loss (more than 10 pounds) ☐ History of Cancer ☐ Bladder problems ☐ History of Steroid medication use
☐ Constipation ☐ Bowel problems ☐ Pain awakens me from sleeping ☐ Other ____________________

Name:
DOB:
Chart:
Age:
Date:



Review of systems: Mark any symptom or condition which you have had or now have.

General: ☐ weight change ☐ loss of appetite ☐ fever ☐ other ____________

Skin: ☐ rashes ☐ lumps ☐ sores ☐ change in color or size of mole ☐ other ____________

Head: ☐ headaches ☐ head injury ☐ other ____________

Eyes: ☐ sudden loss of vision ☐ double vision ☐ cataracts ☐ glaucoma ☐ eye pain ☐ eye redness
☐ other ____________

Ears: ☐ sudden loss of hearing ☐ ringing in ears ☐ vertigo ☐ ear infections ☐ drainage from ear
☐ other ____________

Nose and Sinus: ☐ nosebleeds ☐ sinus infections ☐ other ____________

Mouth and Throat: ☐ dentures ☐ decayed teeth ☐ bleeding gums ☐ sores in mouth ☐ hoarseness
☐ difficulty swallowing ☐ other ____________

Neck: ☐ lumps in neck ☐ swollen glands ☐ goiter ☐ pain or stiff neck ☐ other ____________

Breasts: ☐ lumps ☐ nipple discharge ☐ dimpled skin ☐ other ____________

Respiratory: ☐ recurrent cough ☐ excessive sputum ☐ bloody sputum ☐ wheezing ☐ asthma ☐ emphysema
☐ pneumonia ☐ tuberculosis ☐ positive skin test for TB ☐ shortness of breath ☐ sleep apnea ☐ other ____________

Cardiac: ☐ high or low blood pressure ☐ rheumatic fever ☐ heart attack ☐ chest pain at rest or on exertion
☐ irregular heart rate ☐ swelling of both legs or ankles ☐ sleep on two or more pillows ☐ high cholesterol
☐ other ____________

Blood vessels in legs: ☐ leg cramps when walking ☐ varicose veins ☐ cold feet ☐ sores on feet or ankles
☐ blood clots in legs ☐ other ____________

Gastrointestinal: ☐ heartburn ☐ recurrent nausea or vomiting ☐ recurrent constipation or diarrhea
☐ rectal bleeding ☐ black stool ☐ loss of bowel control ☐ ulcers ☐ hernias ☐ abdominal pain ☐ jaundice
☐ liver or gallbladder problems ☐ hepatitis ☐ colon polyp/tumor ☐ other ____________

Urinary: ☐ frequent urination ☐ burning on urination ☐ recurrent bladder or kidney infections ☐ loss of bladder control
☐ kidney stones ☐ decreased force of urinary stream ☐ blood in urine ☐ other ____________

Male Genital: ☐ drainage from or sores on penis ☐ pain or lump in testicles ☐ prostatitis ☐ scrotal swelling
☐ difficulty in sexual functioning ☐ history of sexually transmitted disease ☐ other ____________

Female Genital: ☐ Date of last menstruation ____________ ☐ age at menopause ____________ ☐ complications of pregnancy ☐ drainage from vagina ☐ sores or lumps in or around vagina ☐ abnormal bleeding ☐ difficulty in sexual function ☐ history of sexually transmitted diseases ☐ other ____________

Nerve Problems: ☐ blackouts ☐ seizure or convulsions ☐ paralysis ☐ frequent or constant numbness in a body part ☐ abnormal memory loss ☐ tremors ☐ history of polio or muscular sclerosis or stroke/TIA ☐ slurred speech
☐ other ____________

Blood Problems: ☐ anemia ☐ easy bruising or bleeding ☐ splenectomy ☐ leukemia ☐ other ____________

Other glands: ☐ overactive or underactive thyroid ☐ diabetes ☐ excessive urination ☐ sweating or thirst ☐ enlarged lymph nodes ☐ other ____________

Emotional problems: ☐ excessive nervousness ☐ worry ☐ anxiety ☐ depression ☐ insomnia
☐ other ____________

Reviewed by ____________ Date ____________

Re-reviewed by ____________ Date ____________

Re-reviewed by ____________ Date ____________