



UNIVERSITY ORTHOPAEDICS AND SPORTS MEDICINE

PATIENT MEDICAL HISTORY

Name: _____ Social Security No.: _____

Birth Date: _____ Age: _____ Gender: M ___ F ___ Occupation: _____

Primary Care Physician: _____ Referred By: _____

Are you currently working? Yes ___ No ___ Where do you work? _____ How long? _____

Briefly describe the main reason for your visit: _____

Is this problem the result of an accident/injury? Yes ___ No ___ Did the accident occur at work? Yes ___ No ___

Date of injury: _____ Days off work: _____ BWC Claim #: _____

Work Status/Restrictions: _____ Attorneys Name: _____

Please list your current medications, including Aspirin, Tylenol, Ibuprofen and other over the counter medications.

Name of Medicine	Dosage		Name of Medicine	Dosage

Please list all allergies: _____

Have you ever been hospitalized? Yes ___ No ___ Had an operation? Yes ___ No ___

Please list all hospitalizations and operations: _____

Social History: Do you smoke? ___ Packs/day: ___ # of Years: ___ Do you drink? ___ Amt./day: ___

(PLEASE CONTINUE ON REVERSE SIDE)

PLEASE INDICATE BELOW WHICH HAVE BEEN PAST MEDICAL PROBLEMS FOR YOU

	Yes	No		Yes	No
Heart disease			Blood clots in your legs, lungs		
High blood pressure (Hypertension)			Neurological disease		
Lung disease (see below):			Have you ever had a stroke?		
Bronchitis			Do you have seizures?		
Emphysema			Cancer		
Asthma			Osteoporosis		
Diabetes			Osteoarthritis, degenerative arthritis		
Ulcer or stomach disease			Rheumatoid arthritis		
Kidney or bladder disease			Other medical problems, please specify:		
Liver disease					
Anemia or any blood disease					

DO YOU HAVE ANY PROBLEMS WITH ANY OF THE ITEMS BELOW? (Please answer Yes or No)

NEUROLOGIC

Thinking clearly _____

Walking _____

Weakness _____

Seizures _____

Dizziness _____

UROGENITAL

Incontinence _____

Retention _____

Urgency _____

Sexual dysfunction _____

Sexual disease _____

Other _____

GASTROINTESTINAL

Constipation _____

Other _____

(Review of Systems – 5 items and all others negative → comp)

CARDIAC AND PULMONARY

Chest pain _____

Palpitations _____

Shortness of breath _____

Heart disease _____

Other _____

MUSCULOSKELETAL

Arthralgias _____

Pain _____

Swelling _____

Limited motion _____

HEENT

Glasses _____

Visual change _____

Hearing change _____

ENDOCRINE Diabetes: _____ Thyroid disorder: _____

CANCER HISTORY _____ **CONSTITUTIONAL** Weight loss: _____

BLOOD DISORDER/VASCULAR _____

PSYCHIATRIC Illness: _____ Sleep disturbance: _____

Family History: _____

Your current height: _____ Feet _____ Inches Your current weight: _____ pounds

Patient Signature: _____ Date: _____

BP: _____ / _____ Heart Rate: _____ Respiratory Rate: _____ Temperature: _____

Physician Signature: _____ Date: _____

(Exam: (18 or more items → comp))