Patient Name:________________________
GW Account #:_______________________
Date:____/____/____

ALABAMA ORTHOPAEDIC CLINIC, P.C.
MEDICAL HISTORY FORM

MEDICAL HISTORY:

Patient Name:____ Age:_________ Sex: ☐ F ☐ M

Height:___________ Weight:____________ Dominant Hand: ☐ R ☐ L Did you bring X-rays: ☐ Y ☐ N

What is your Chief Complaint:

What part of the body are you being seen for today:____ ☐ R ☐ L

Did you have a specific injury? ☐ Y ☐ No Injury Describe:______________________________
If yes please specify ☐ At work ____________________________________
☐ Auto Injury ____________________________________
☐ Other:

When did symptoms first begin?:______________________________ Have you ever had similar symptoms: ☐ Y ☐ N

Where you seen in the ER for this problem? ☐ Y ☐ N
If yes please specify Where: __________________________ When: __________________________

Have you seen any other healthcare providers for this problem? ☐ Y ☐ N
If yes please specify Who:______________________________

Have you had any treatments or surgery for this or a related problem? ☐ Y ☐ N If yes, Where?_________________
(X-Ray's, MRI, CT Scan, Bone Scan, Nerve Study)

Have you had any of these treatments? ☐ Injections ☐ Brace ☐ Physical Therapy ☐ Cane/Crutch
If yes, did your situation get ☐ Better ☐ Worse ☐ Stay the same

What is your current work status:________________________________ Last day worked:_________________________

On a scale of 0-10 (10 being the worst) how sever is your pain? (Circle) 0 1 2 3 4 5 6 7 8 9 10

What is the quality of the pain: ☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning

The pain is: ☐ Constant ☐ Comes and goes (intermittent)

Does your pain wake you from sleep? ☐ Y ☐ N

Any Associated symptoms: ☐ Bruising ☐ Swelling ☐ Numbness ☐ Tingling ☐ Weakness ☐ Instability
☐ Bladder or Bowel problems ☐ Locking/Catching

Since problem started are you: ☐ Better ☐ Worse ☐ Unchanged

What makes it better?____

What makes it worse?____

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MEDICAL HISTORY FORM

☐ Y ☐ N

PAST MEDICAL HISTORY:

Are you Diabetic (blood sugar problems?) ☐ Y ☐ N

Do you have Sleep Apnea (breathing problems with sleep)? ☐ Y ☐ N

List any medical problems you have or have had:____

Do you have GERD (gastric esophageal reflux disorder, Heartburn, Stomach Acid)? ☐ Y ☐ N

Have you ever had?

__Cancer	__Radiation/Chemotherapy	__Migraine/Head Aches
__High Blood Pressure	__Chronic Fatigue Syndrome	__Blood Clots
__Stroke	__Thyroid Trouble	__Kidney Infections
__Heart Attack	__Seizures	__Ulcer
__Tuberculosis	__Hepatitis	__Other

FAMILY MEDICAL HISTORY:

Do you have a family history of: ☐ Bleeding Disorders ☐ Heart Disease ☐ Cancer ☐ Diabetes?
If yes please explain, Mother, Father, Grandmother etc.____

PAST SURGICAL HISTORY:

Have you had any surgeries? ☐ Y ☐ N
If yes please list:____

Any complications:____

MEDICATIONS:

Are you currently taking any medications? ☐ Y ☐ N
If yes please specify:____

Are you taking any Blood Thinners (Coumadin, Warferin, Aspirin, Baby Aspirin)? ☐ Y ☐ N

ALLERGIES:

Any known Drug Allergies:____
(Including: Drugs, Latex, Nickel, Metal, Food, Dyes, Other)

Can you take Anti-Inflammatory medications? ☐ Y ☐ N

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ALABAMA ORTHOPAEDIC CLINIC, P.C.
MEDICAL HISTORY FORM

SOCIAL HISTORY:

Do you use tobacco? ☐ Y ☐ N If yes, packs per day____ Patients informed of smoking risk ☐ Y ☐ N

Alcohol Use? ☐ Y ☐ N If yes, how often and how much: ☐ Daily ☐ Weekly_______

Drug Addiction: ☐ Never ☐ Presently ☐ Past

Marital History: ☐ M ☐ S ☐ D ☐ W How many people live with you?_________________________________

Occupation:____ ☐ Student

Employer:____

REVIEW OF SYSTEMS:

Do you have any problems with the following: If yes please describe:

Eyes	☐ Y	☐ N
Ear, Nose, Throat and Mouth	☐ Y	☐ N
Fever/Chills/Weight Loss	☐ Y	☐ N
Heart/Circulation (Heart Attack, Blood Clots)	☐ Y	☐ N
Lungs (Asthma, Bronchitis)	☐ Y	☐ N
Stomas (Ulcer, Hernia)	☐ Y	☐ N
Urinary System (Prostate, Kidneys)	☐ Y	☐ N
Bone and Joints	☐ Y	☐ N
Skin/Breast	☐ Y	☐ N
Neurological	☐ Y	☐ N
Psychiatric	☐ Y	☐ N
Bleeding Problems	☐ Y	☐ N

OTHER/NOTES:

Patient Name:________________________
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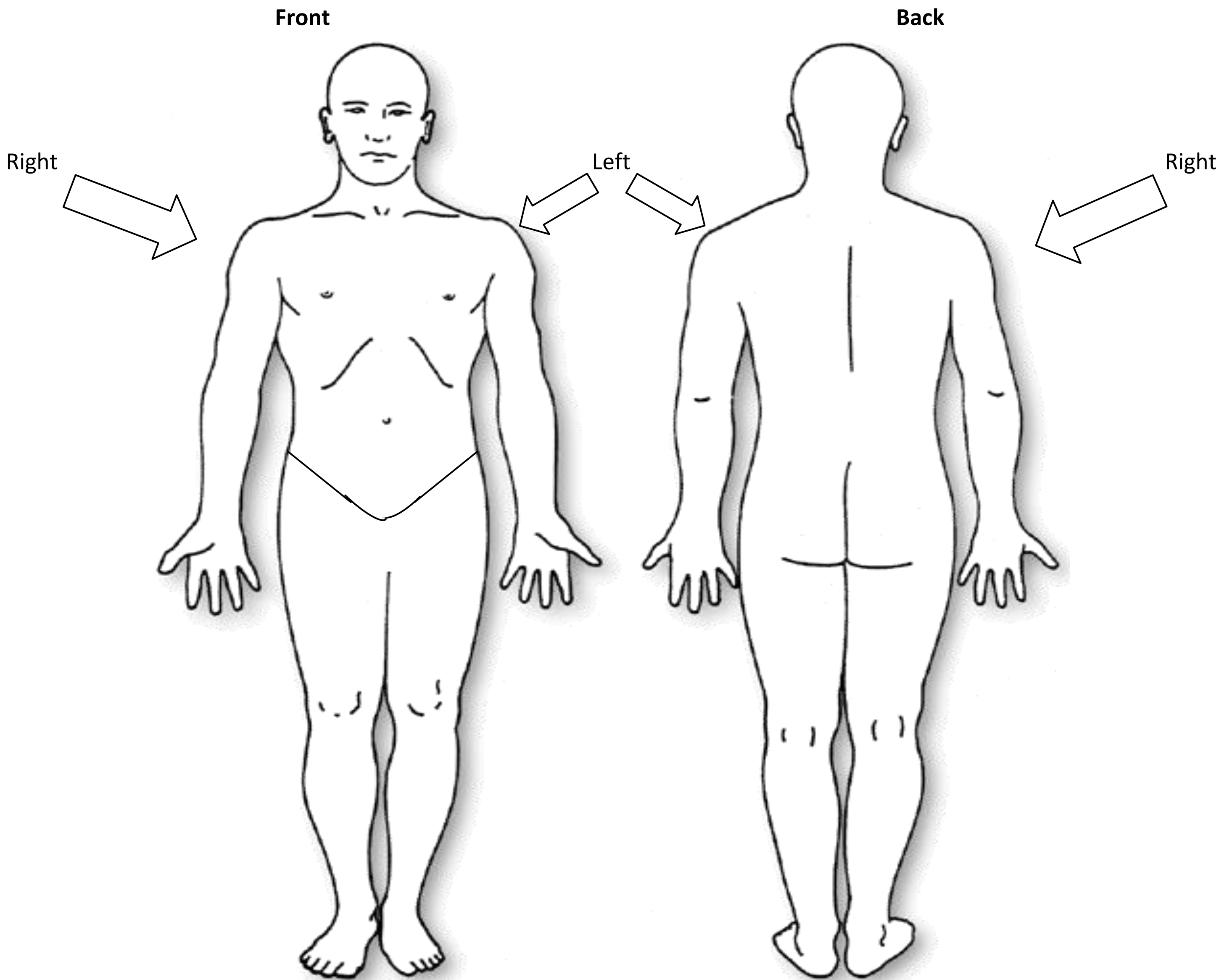
ALABAMA ORTHOPAEDIC CLINIC, P.C.
MEDICAL HISTORY FORM

Mark the areas of your body where you now feel your typical pain.

Including all affected areas. Use the appropriate symbols indicated below:

PAIN=XXXXXX NUMBNESS=OOOOOO



Pain Diagram