

**ALABAMA ORTHOPAEDIC CLINIC, PC**

**PATIENT MEDICAL INFORMATION SHEET**

Date \_\_\_\_\_ Chart # \_\_\_\_\_

Please ask for assistance if you have any questions while entering your medical history on this sheet.

Name \_\_\_\_\_ Age \_\_\_\_\_ M/F Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Who referred you? (friend/doctor/other) \_\_\_\_\_

Why are you seeing the doctor today? \_\_\_\_\_

Did you have an injury? Y / N Where? \_\_\_\_\_ When? \_\_\_\_/\_\_\_\_/\_\_\_\_ Work Related? Y / N

Where is your pain? \_\_\_\_\_ When did it start? \_\_\_\_\_

Describe your pain by circling a word or words below:

Dull / Sharp / Cramping / Burning / Stinging / Mild / Moderate / Severe / Improving / Worsening

What makes your Pain Better? \_\_\_\_\_

What makes your Pain Worse ? \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Are you Right \_\_\_\_\_ or Left Hand \_\_\_\_\_ Dominant?

**PAST MEDICAL HISTORY**

Please explain how long and treatment given:

- Diabetes Y/N \_\_\_\_\_
- Heart Disease Y/N \_\_\_\_\_
- Stroke Y/N \_\_\_\_\_
- Peptic Ulcer Disease Y/N \_\_\_\_\_
- Blood Clots Y/N \_\_\_\_\_
- High Blood Pressure Y/N \_\_\_\_\_
- Asthma Y/N \_\_\_\_\_
- Hepatitis B/C Y/N \_\_\_\_\_
- Tb Y/N \_\_\_\_\_
- HIV Y/N \_\_\_\_\_
- Other Y/N \_\_\_\_\_

**PAST SURGICAL HISTORY**

Have you had a Bone Density Exam / Screening for Osteoporosis before? Y / N If yes, how long ago? \_\_\_\_\_

Have you had a MRI related to this problem? Y / N If yes, how long ago? \_\_\_\_\_

Have you had an X-ray related to this problem? Y / N If yes, how long ago? \_\_\_\_\_

**PAST SURGICAL HISTORY**

NONE \_\_\_\_\_

Surgeries/Hospitalizations	Year	Complications

**MEDICATIONS**

NONE \_\_\_\_\_

Medications/Herbal	Dose	Reason for Medication	Side Effects

**ALLERGIES** \_\_\_\_\_ **NONE** If you have allergies please list: \_\_\_\_\_

**FAMILY HISTORY**

Has anyone in your family had:

Cancer/Diabetes/Heart Attack/Rheumatoid Arthritis/Lupus/Death before 50 yrs old/High Blood Pressure/Other

Please Explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SOCIAL HISTORY**

Are you?

Single / Married / Divorced / Separated / Widowed      Children? Y / N    Do you live alone? Y / N

Retired / Homemaker

Student    Where? \_\_\_\_\_      What Year? \_\_\_\_\_

Employed / Unemployed    Where? \_\_\_\_\_      Occupation? \_\_\_\_\_

Education Level: High School / College / Graduate Education

Exercise: Daily / Weekly / Rarely / Never      What type of exercise? \_\_\_\_\_

Smoke Y / N \_\_\_\_\_ Packs a day for \_\_\_\_\_ years Quit Y / N \_\_\_\_\_ years

Drink Alcohol? \_\_\_\_\_ Daily \_\_\_\_\_ 1-2 x/week \_\_\_\_\_ 1-2 x/month \_\_\_\_\_ 1-2 x/year \_\_\_\_\_ None

**REVIEW OF SYSTEMS**

Please circle the item(s) below for which you are currently having or have had problems with

- Fever - Chills - Weight Loss - Fatigue - Difficulty Sleeping
- Previous Broken Bones - Arthritis - Osteoporosis - Back Pain - Neck Pain
- Headaches - Fainting - Dizziness - Blurred Vision
- Sore Throat - Ringing in Ears - Nosebleeds - Ear Ache - Difficulty Swallowing
- Shortness of Breath - Cough - Wheezing
- Chest Pain - Skipped Beats - Racing Heart - Palpitations
- Ulcers - Vomit Blood - Blood or Tarry Stools - Indigestion - Gallbladder - Reflux
- Blood in Urine - Urine Retention - Loss of Control - Uterus - Prostate
- Rash - Itching - Hives - Poor Wound Healing
- Anxiety - Depression - Numbness or Tingling - Seizures - Concussion

Please explain circled answers: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Review Dates \_\_\_\_/\_\_\_\_/\_\_\_\_    \_\_\_\_/\_\_\_\_/\_\_\_\_    \_\_\_\_/\_\_\_\_/\_\_\_\_  
\_\_\_\_/\_\_\_\_/\_\_\_\_    \_\_\_\_/\_\_\_\_/\_\_\_\_    \_\_\_\_/\_\_\_\_/\_\_\_\_