Name: _____
MRN: _____
Date: _____

ROSENBERG COOLEY METCALF
THE ORTHOPEDIC CLINIC AT PARK CITY

PATIENT MEDICAL HISTORY

Occupation: _____ M / F Height: _____ Weight: _____

Referring Physician: _____ Age: _____ Date of birth: _____

Chief Complaint/History of Present Illness

In your own words, what is (are) your specific concerns(s)? _____

_____

_____

Rate the pain (Please circle: 0= no pain; 10=most severe) 0 1 2 3 4 5 6 7 8 9 10

What activities/medications help your condition? _____

_____

What previous treatment have you had for this problem? _____

_____

Have you had a fall in the last twelve months? Yes No Have you received a flu shot? Yes No

MED**ICAL HISTORY:** -Please check/circle any of the following that you have had:

____ Diabetes: type 1 or 2	___ Asthma	___ Muscle Disorders
____ Thyroid Problems	___ Tuberculosis (TB)	___ Mental Health Disorders
____ Heart Problems	___ Liver Problems	___ Skin Disorders
____ Elevated Cholesterol	___ Blood Clots or Bleeding Disorders	___ Sleep Apnea
____ High Blood Pressure	___ Kidney, Bladder or Prostate Problems	___ Severe/Migraine Headaches
____ Stroke	___ Stomach Ulcer or Reflux Problems	___ Arthritis RA OA
____ Seizures	___ Difficulty Opening Mouth	___ Cancer – Type/Location ___

_____

Other serious health conditions: _____

SURGICAL HISTORY:-Please list any previous surgeries you have had:

SURGERY	DATE	PHYSICIAN	HOSPITAL	CITY/STATE

CURRENT MEDICATIONS:-Please list all medications you are currently taking:

MEDICATION	DOSAGE (mg, mcg, etc.)	FREQUENCY (times per day, as needed, etc.)

ALLERGIES: Are you allergic to latex? YES NO

Are you allergic to any medications? YES NO

If YES, list medication and reaction: _____

List any other allergies: _____

SOCIAL HISTORY:

Do you use tobacco/nicotine? YES NO Form of tobacco:

Frequency of daily use (eg., 2 packs per day) _____

Do you drink alcoholic beverages? YES NO Average # of drinks per week: _____

Do you have a history of substance abuse? YES NO

FAMILY HISTORY:

Has or does anyone in your family have any of the following?

Heart Trouble	YES	NO	Relationship	_____
Diabetes	YES	NO	Relationship	_____
Tuberculosis	YES	NO	Relationship	_____
High Blood Pressure	YES	NO	Relationship	_____
Pneumonia	YES	NO	Relationship	_____
Cancer	YES	NO	Relationship	_____
Sudden Death	YES	NO	Relationship & Cause:	_____
Arthritis	YES	NO	Relationship	_____
Blood Clots	YES	NO	Relationship	_____

REVIEW OF SYSTEMS:

MUSCULOSKELETAL:

Do you have any chronic or intermittent back pain? YES NO

Do you have problems with any other joints such as pain, swelling, stiffness or weakness? YES NO

If YES, please explain: _____

SKIN:

Do you have any rashes, lesions, lumps or sores? YES NO

If YES, please explain: _____

NEUROLOGICAL:

Do you have history of seizures or other nervous system disorders requiring medication? YES NO

If YES, please explain:

Do you have any previous history of stroke? YES NO

Do you have any problems with headaches or dizziness? YES NO

PSYCHIATRIC:

Do you have a drug or alcohol addiction? YES NO

Do you have any problems with depression? YES NO

ENDOCRINE:

Do you have any problems with excessive thirst or intolerance to heat or cold? *(please circle all that apply)* YES NO

HEMATOLOGY:

Do you have any problems with easy bleeding or bruising? *(please circle all that apply)* YES NO

Do you have any problems with anemia? YES NO

Have you ever had a blood clot? YES NO

CONSTITUTIONAL:

Have you had any recent coughs or colds? YES NO

EYES:

Do you have any tearing, eye pain, pressure or change in vision? YES NO

If YES, please explain: YES NO

EAR, NOSE, & THROAT:

Do you have any sore throats? YES NO Do you have difficulty hearing? YES NO

CARDIOVASCULAR:

Do you have any chest or arm pain on exertion? YES NO

Do you have chronic cough either dry or with blood or sputum? YES NO

GASTROINTESTINAL:

Do you have gastritis? YES NO Do you have diverticulitis? YES NO

Do you have colitis? YES NO Do you have hepatitis? YES NO

OTHER CONSIDERATIONS:

Do you have vision or hearing disabilities? YES NO Please specify: _____

Do you have any physical limitations? YES NO Please specify: _____

Is there anything else we should know about you? _____

PATIENT SIGNATURE: _____