Name: _____

Date: _____

ROSENBERG COOLEY METCALF
THE ORTHOPEDIC CLINIC AT PARK CITY

DR. METCALF PATIENT MEDICAL HISTORY

Occupation: _____ M / F Height: _____ Weight: _____
Referring Physician: _____ Age: _____ Date of Birth: _____

Chief Complaint/History of Present Illness

What is (are) your specific concern(s)? _____
_____
Date of onset: _____ Did you sustain an injury? YES NO Was it work related? YES NO
If not work related, during what activity? _____
Are you currently doing physical therapy? YES NO If yes, where? _____
Have you had previous shoulder surgery? YES NO If yes, please describe _____
Have you had any shoulder injections? YES NO If yes, date(s)? _____
Have you had a flu shot in the last 12 months? YES NO

MEDICAL HISTORY Please check any of the following that apply to you and describe below:

___ Diabetes: Insulin YES NO	___ Asthma	___ Muscle Disorders	___ Thyroid Problems
___ Tuberculosis (TB)	___ Mental Health Disorders	___ Heart Problems	___ Liver Problems
___ Skin Disorders	___ Blood Clots	___ Elevated Cholesterol	___ Sleep Apnea
___ High Blood Pressure	___ Kidney, prostate problem	___ Severe/Migraine Headache	___ Stroke
___ Stomach ulcer/reflux	___ Arthritis RA OA	___ Seizures	___ Mouth difficulty

___ Cancer: type/location _____
Describe above conditions:_____

SURGICAL HISTORY Please list any previous surgeries you have had:

SURGERY	DATE	PHYSICIAN	HOSPITAL	CITY/STATE

MEDICATION Please list all medications and dosage:

_____
_____
_____
_____
_____

ALLERGIES

Are you allergic to any medications? YES NO
If yes, list medication(s) AND reaction: _____
Are you allergic to latex? YES NO

SOCIAL HISTORY:

Do you use tobacco/nicotine? YES NO If yes, form of nicotine:_____
Frequency of daily use (eg., 2 packs per day) _____
Do you drink alcoholic beverages? YES NO If yes, average # of drinks per week: _____
Do you have a history of substance abuse? YES NO If yes, describe: _____
_____

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

Heart trouble	YES	NO	Relationship _____
Diabetes	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 _____

REVIEW OF SYSTEMS:

Constitutional

Have you had any recent coughs or colds? YES NO

Skin

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

If yes, please explain: _____

Eyes

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

If yes, please explain: _____

Ear, Nose, & Throat

Do you have a history of sore throats? YES NO

Do you have difficulty hearing? YES NO

Cardiovascular

Do you have any chest pain on exertion? YES NO

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

Gastrointestinal

Do you have gastritis, colitis or diverticulitis? YES NO

If yes, please explain: _____

Do you have hepatitis? YES NO

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: _____

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

Hematology

Do you have any problems with easy bleeding? YES NO

Do you have any problems with easy bruising? YES NO

Do you have any problems with anemia? YES NO

Have you ever had a blood clot? YES NO

Endocrine

Do you have any problems with excessive thirst or intolerance to heat or cold? YES NO

Psychiatric

Do you have any drug or alcohol addiction? YES NO

Do you have any problems with depression? YES NO

Patient Signature: _____ Date _____