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

Did you sustain an injury? YES NO If so, date _____

Was it work related? YES NO If not, during what activity _____

What previous treatments have you had for this problem? _____

_____

Are you right or left hand dominant? _____

Have you had a flu shot in the last 12 months? YES NO

I have reviewed this patient's medical history sheet as they have recorded it

Signed:

_____

Provider's Signature

_____

Date

MEDICAL HISTORY: Please check any of the following that you have had:

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

Arthritis YES NO Relationship _____

Problems with Anesthesia 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

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

Do you have any previous history of stroke? YES NO

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

ENDOCRINE:

Do you have any problems with excessive thirst or intolerance to heat or cold? 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

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:

Have you had a recent sore throat? YES NO Do you have difficulty hearing YES NO

CARDIOVASCULAR:

Do you have 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? 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 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: _____