

Name: _____
 MRN: _____
 Date: _____



Dr Pidwell

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

<p>In your own words, what is (are) your specific concerns(s)? _____ _____ _____</p> <p>Rate the pain (Please circle: 0= no pain; 10=most severe) 0 1 2 3 4 5 6 7 8 9 10</p> <p>What activities/medications help your condition? _____ _____</p> <p>What previous treatment have you had for this problem? _____ _____</p> <p>Are you right or left hand dominant? _____</p>	<p>How long have you had the pain/problem? _____ _____</p> <p>Did you sustain an injury? Yes No</p> <p>Date of injury: _____</p> <p>Was it work related? Yes No</p> <p>If yes, what is your current work status? _____ _____</p> <p>If no, during what activity? _____ _____</p>
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MEDICAL HISTORY: -Please check any of the following that you have had:

- | | | |
|--|---|---|
| <input type="checkbox"/> Diabetes: type 1 or 2 | <input type="checkbox"/> Asthma | <input type="checkbox"/> Muscle Disorders |
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Tuberculosis (TB) | <input type="checkbox"/> Mental Health Disorders |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Skin Disorders |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Elevated Cholesterol | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney, Bladder or Prostate Problems | <input type="checkbox"/> Severe/Migraine Headaches |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Stomach Ulcer or Reflux Problems | <input type="checkbox"/> Arthritis RA OA |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Difficulty Opening Mouth | <input type="checkbox"/> Cancer - Type/Location _____ |

Other serious health conditions: _____ Have you had a flu shot in the last year? YES NO

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?

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	_____

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

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? 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:

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

CARDIOVASCULAR:

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 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: _____

PROVIDER'S

SIGNATURE: _____