ATLANTIC ORTHOPAEDICS - Initial Patient Medical History

Physicians initials ________

Name:	Date:	SSN:	Patient ID:

Date of Birth:	Age:	Height:	Weight:	Sex: M [ ] F [ ]

Employer:	Job Title:	How long have you worked there?
Date of Accident:	When did your pain start?	Side of discomfort/problem [ ] left [ ] right [ ] midline

Family/Medical Doctor:	Referred by:

Pharmacy Name:	Location:	Telephone:

Reason for **today's** visit: ________________________________

Have you ever injured this area before? ________________________________

How were you hurt? ________________________________

What makes your symptoms better? ________________________________

What makes your symptoms worse? ________________________________

MEDICAL HISTORY: At any time have you had:

- [ ] diabetes
- [ ] stroke
- [ ] seizures
- [ ] glaucoma
- [ ] ear, nose, throat or mouth problem
- [ ] thyroid trouble
- [ ] lung/breathing problem
- [ ] heart problem
- [ ] high blood pressure
- [ ] breast disease/cancer
- [ ] stomach ulcers
- [ ] liver disease
- [ ] hepatitis
- [ ] pancreatitis
- [ ] gallstones
- [ ] bowel/intestinal problem
- [ ] kidney disease
- [ ] kidney stones
- [ ] prostate disease
- [ ] gynecologic disease
- [ ] anemia
- [ ] bleeding disorder
- [ ] blood clots
- [ ] cancer
- [ ] HIV/AIDS
- [ ] blood transfusion
- [ ] skin disease
- [ ] mental health disorder
- [ ] drug abuse
- [ ] alcohol abuse

[ ] other (please explain): ________________________________

In the past 6 months have you had?

- [ ] repeated fevers
- [ ] weight loss
- [ ] vision problem
- [ ] hearing difficulty
- [ ] sinus/allergy problems
- [ ] shortness of breath
- [ ] irregular heartbeat/palpitations
- [ ] heartburn
- [ ] diarrhea
- [ ] painful/frequent urination
- [ ] joint pain
- [ ] skin rash
- [ ] blackouts
- [ ] depression/anxiety
- [ ] low energy level
- [ ] chest pain
- [ ] fatigue
- [ ] tingling/numbness

List previous surgeries	Year of surgery

List date of last:	
Colonoscopy	
Mammogram	
PAP Smear	
Flu Vaccine	
Pneumoccal Vaccine	

-OVER-

ATLANTIC ORTHOPAEDICS - Initial Patient Medical History (cont.)

Physicians initials ________

List current medications	Dose	How often?

List drug allergies	Allergic Reaction

FAMILY HISTORY: Have any of your relatives had:

[ ] diabetes
[ ] rheumatoid arthritis
[ ] high blood pressure
[ ] cancer
[ ] heart disease
[ ] neck or back problems
[ ] other (explain): ________

SOCIAL HISTORY:

Marital Status: [ ] married [ ] single [ ] divorced [ ] widowed
Do you have children? [ ] no [ ] yes how many? ________
Work Status: [ ] employed [ ] homemaker [ ] retired [ ] unemployed [ ] disabled
Occupation: ________
Worker's Compensation claim for today's problem: [ ] yes [ ] no
Current Smoker? [ ] no [ ] yes packs/day ________ years ________
Former Smoker? [ ] no [ ] yes year quit ________
Alcohol use: [ ] never or rarely [ ] once a day [ ] once a week [ ] once a month
Hobbies/sports/interests: ________
Regular exercise: [ ] none [ ] occasionally [ ] regular
Type of exercise (explain): ________

Please mark the following diagrams to indicate where your discomfort is

PAIN SCALE
(indicate your level of pain)

1 (low)
2
3
4
5
6
7
8
9
10 (high)

Are you: [ ] RIGHT or [ ] LEFT handed