MEDICAL HISTORY FORM

ORTHOPEDIC SURGERY

Date:______________________________ Referred By:______________________________________

Name (Print):____ Age:________ Birthdate:__________________

Height:________ Weight:_____________ Name of Private Medical Doctor:____

When completed, the medical history included here can be of critical importance to you and your physician, it provides a general synopsis of your entire health background, points up areas worthy of additional investigation and analysis and materially increases the effectiveness of your physician's personal contact with you. Less time need be spent on the gathering of important background information and more time can be utilized pursuing in detail the more pertinent and critical areas, which you will have brought into focus here.

In this period of rapidly expanding medical knowledge and increasing specialization associated therewith, there is a very real risk of the specialist physician not being keenly aware of the general health and medical background of the patient. On occasion such information critically affects the diagnosis and treatment of the current medical problem which sometimes to the patient may seem a separate and unrelated entity.

Please complete thoughtfully each item of the following **MEDICAL HISTORY** and have it available to the physician when you are seen.

PRESENT ILLNESS	Please Print Your Answer	Physician's Comments
1) For what condition or symptoms are you being seen at this time?		
2) When did the accident occur or symptoms or condition first come upon you?		
3) History of Illness: In outline form, please try to give a chronological list of step by step history of the progression of symptoms from onset to present. When possible, record the approximate dates of changes or developments.		
4) Is there any history of this or a similar problem prior to the current condition or symptoms?		

(PLEASE COMPLETE NEXT PAGE)

ORTHOPEDIC SCREEN (check yes or no)

Have you ever had?

	Yes	No	Explanation
Bursitis	☐	☐	
Arthritis	☐	☐	
Tendinitis	☐	☐	
Gout	☐	☐	
TB	☐	☐	
Diabetes	☐	☐	
Back Pain	☐	☐	
Disc Disease	☐	☐	
Fractures (give dates)	☐	☐	

PAST MEDICAL HISTORY:

Medications (Dose/Frequency): ______

Allergies to Medications: ______

Operations (Give Dates): ______

Serious Illnesses: ______

Hospitalizations (Give Dates): ______