

PATIENT MEDICAL HISTORY

Patient Name: _____ Email: _____
FIRST MIDDLE LAST

Medical Conditions:

Please check those you currently have or have had in the past (provide specifics where applicable):

<input type="checkbox"/> Arthritis _____	<input type="checkbox"/> Hearing Loss _____
<input type="checkbox"/> Asthma / Emphysema / COPD _____	<input type="checkbox"/> Heart Condition _____
<input type="checkbox"/> Blood Clot _____	<input type="checkbox"/> Hernia _____
<input type="checkbox"/> Bowel/Bladder _____	<input type="checkbox"/> High Blood Pressure _____
<input type="checkbox"/> Bronchitis _____	<input type="checkbox"/> Numbness / Tingling _____
<input type="checkbox"/> Cancer _____	<input type="checkbox"/> Osteoporosis (bone thinning) _____
<input type="checkbox"/> Chest Pain _____	<input type="checkbox"/> Pacemaker _____
<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> Seizures _____
<input type="checkbox"/> Dizziness _____	<input type="checkbox"/> Sprains / Strains / Fractures _____
<input type="checkbox"/> Frequent Headaches _____	<input type="checkbox"/> Vision Disorders _____
<input type="checkbox"/> Frequent Nausea _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Gout _____	<input type="checkbox"/> Other _____

Hospitalization/Surgical History:

Please list all previous hospitalizations, surgeries/operations and serious illnesses:

HOSPITALIZATION/SURGERY/OPERATION	REASON	YEAR
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____

Medications:

Please include prescriptions, non-prescription and herbal supplements:

DRUG NAME	DOSAGE	FREQUENCY	REASON FOR TAKING
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____

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Please indicate your functional abilities in the following areas:

Sitting longer than 15 minutes

None Slight Minimal Moderate Severe N/A

Standing longer than 15 minutes

None Slight Minimal Moderate Severe N/A

Walking longer than 15 minutes

None Slight Minimal Moderate Severe N/A

Lifting

None Slight Minimal Moderate Severe N/A

Sleeping

None Slight Minimal Moderate Severe N/A

Recreational Activities

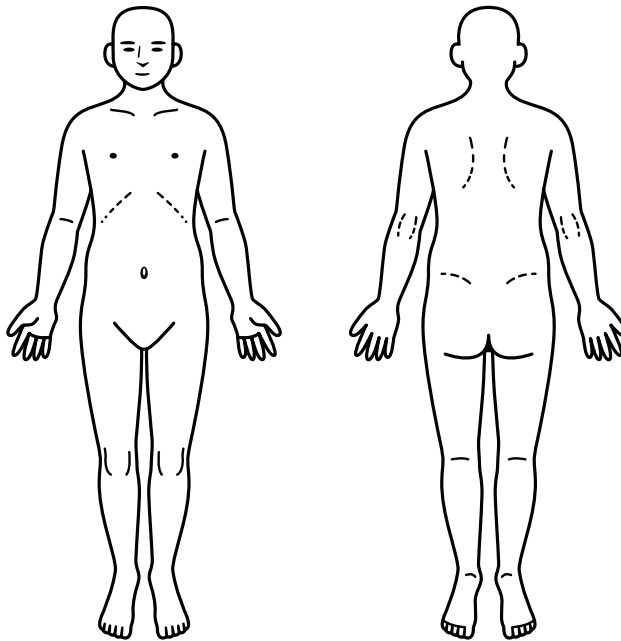
None Slight Minimal Moderate Severe N/A

Work Activities

None Slight Minimal Moderate Severe N/A

PLEASE INDICATE BELOW WHERE YOUR PAIN IS LOCATED:

This may be filled out when you arrive at office.



CHOOSE A NUMBER 0 TO 10 THAT BEST DESCRIBES YOUR PAIN:

NO PAIN	MILD PAIN	MODERATE PAIN	SEVERE PAIN	WORST PAIN POSSIBLE						
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10

How do you prefer to learn new information?:

- Pictures
- Demonstration
- Verbally

My goal for rehabilitation is:

Social History:

OCCUPATION: _____

- | Employment | Dominant Hand | Are you Pregnant? |
|--|--------------------------------|------------------------------|
| <input type="checkbox"/> Retired | <input type="checkbox"/> Right | <input type="checkbox"/> Yes |
| <input type="checkbox"/> Working Part-Time | <input type="checkbox"/> Left | <input type="checkbox"/> No |
| <input type="checkbox"/> Full-Time | | |
| <input type="checkbox"/> Student | | |

Allergies:

Please check those you currently have or have had in the past:

- Adhesive
- Latex
- Lotions
- Other: _____
- Other: _____

Agreement of Accuracy: The information provided in this history form is true and complete to the best of my knowledge.

Notice of Privacy Practices: I am aware that Andrews Orthopaedic and Sports Medicine Center has a “Notice of Privacy Practices” in accordance with Baptist Health Care’s privacy policies. I understand that a copy is available to me and I agree with these policies.

X _____

Date: _____