

PATIENT MEDICAL HISTORY

Patient Name: _____ Email: _____
FIRST M.I. 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	
<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"/> Gout		<input type="checkbox"/> Other	

Hospitalization/Surgical History:

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

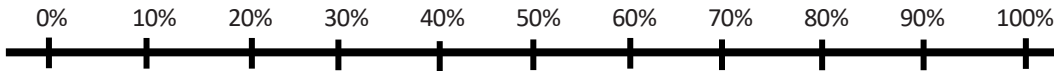
HOSPITALIZATION/SURGERY/OPERATION	REASON	YEAR
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____

Medications:

Please include prescriptions, non-prescription and herbal supplements:

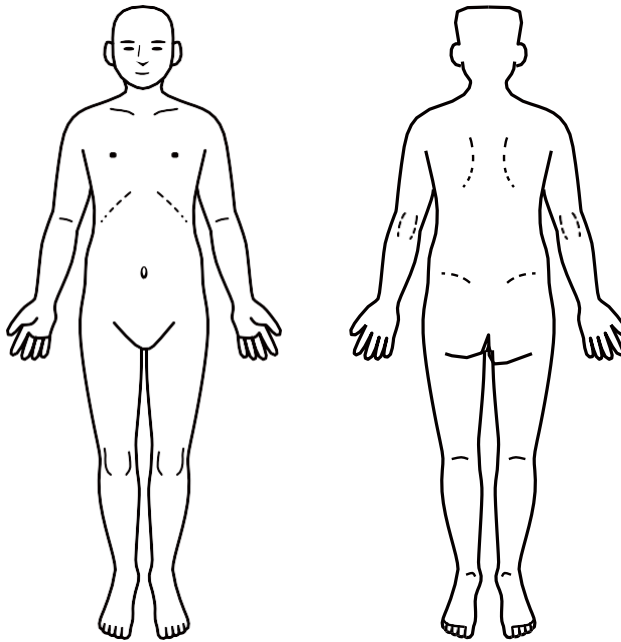
DRUG NAME	DOSAGE	FREQUENCY	REASON FOR TAKING
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____

How would you rate your affected joint/region of interest today as a percentage of normal, where 0% is completely abnormal and 100% is normal?

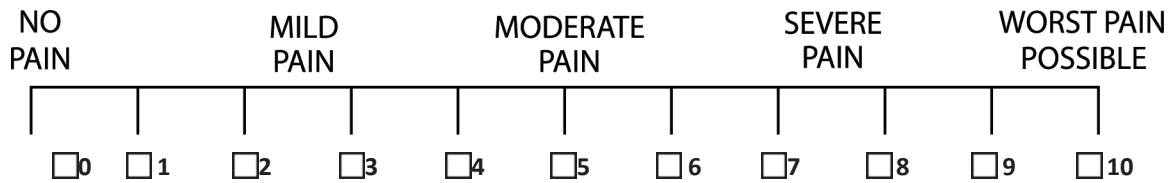


PLEASE INDICATE BELOW WHERE YOUR PAIN IS LOCATED:

This may be filled out when you arrive at office.



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



How do you prefer to learn new information?

- Pictures Demonstration Verbally

My goal for rehabilitation is:

Employment

- Retired
- Student
- Working part or full time

Dominant Hand

- Right
- Left

Are you pregnant?

- Yes
- No

Occupation: _____

Allergies:

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

- Adhesive
- Latex
- Lotion
- 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: _____