

Date _____
Account # _____
Physician _____

Midwest Orthopaedic Institute, S.C.
Patient History Sheet

Patient Name: _____ Date of Birth _____ Age _____

Reason for today's visit: _____ Male/Female Height: _____ Weight: _____

Date of injury/Onset of pain (*required*) _____ Is your pain/injury a result of an accident? Y N

If yes, what type of accident? _____

Is this a work related injury? (*required*) Y N If yes, did you file a Workers Comp Claim? Y N

Did you notify your employer? Y N Are you still working? Y N If no, your last day of work: _____

Past Medical History: Primary Physician: _____ Referring Doctor/Source _____

Shoe size: _____ Are you Right / Left Handed?

Review of Systems: Check if you have problems currently or have had in past

	YES	NO	If yes, please explain:
Eyes/Ears/Nose/Throat	()	()	_____
Respiratory Problem (asthma, COPD, Lung Disease).....	()	()	_____
Heart Disease (heart attacks, Mitral valve prolapse,CHF).....	()	()	_____
High Cholesterol.....	()	()	_____
Blood/Bleeding Disorders/Anemia.....	()	()	_____
Phlebitis, Blood Clots.....	()	()	_____
Peripheral Vascular Disease.....	()	()	_____
Hypertension (High Blood Pressure).....	()	()	_____
Diabetes.....	()	()	_____
Alzheimer's Disease.....	()	()	_____
Parkinson's Disease.....	()	()	_____
Neurological Problems (seizures, strokes).....	()	()	_____
Stomach Ulcers or other Gastrointestinal Problems.....	()	()	_____
Cancer (what kind?) (Lymphoma?).....	()	()	_____
Hepatitis.....	()	()	_____
Tuberculosis.....	()	()	_____
Polio.....	()	()	_____
Skin problems.....	()	()	_____
Musculoskeletal Problems (arthritis,scoliosis,osteoporosis)....	()	()	_____
Kidney/Bladder/Prostate Disease.....	()	()	_____
Thyroid Problems (hyper/hypo).....	()	()	_____
Have you gone through Menopause.....	()	()	At What Age _____
Psychiatric Problems.....	()	()	_____
Sexually Transmitted Disease.....	()	()	_____
HIV Disease.....	()	()	_____
Any other medical condition.....	()	()	_____

****PLEASE COMPLETE OTHER SIDE****

Past Social History:

Occupation: _____

Marital Status: S M W D Do you live alone or with family?: _____

Do you smoke? Y N Amount: _____ Did you quit smoking? Y N When _____

Do you use alcohol? Y N Amount: _____ Type: _____

Do you exercise? Y N How Often: _____

History of substance abuse Y N What? _____

Activities or sports you're involved in: _____

Past Surgical History: Please List **all** surgeries and dates that you have had

Do you have Allergies to Food or Drugs? Y N

Please describe:

Medications: See attached list

Please list **ALL** prescription, over-the-counter, and herbal medications you may be taking. Also, please list the dosage, frequency, and reason for each medication.

<i>Name of Medication</i>	<i>Dosage</i>	<i>Frequency</i>	<i>Reason</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Past Family History:

Major Medical Problems or Cause of Death:

Mother: Alive/Deceased _____

Father: Alive/Deceased _____

Siblings: Alive/Deceased _____

Alive/Deceased _____

Patient/Parent Signature: _____ Date: _____

Ortho Tech Signature: _____ Doctor Initials _____ Date: _____