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………………………………..….	( )	( )	____________________
Have you had a bone density scan, also called dual-energy x-ray absorptiometry (DEXA) at least once since the age of 60?	( )	( )	N/A When? ________________

****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** **Pharmacy:** __________ **(city)** __________

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.

Name of Medication	*Dosage*	*Frequency*	*Reason*

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:__________

Ortho Tech Signature:__________Doctor Initials__________ Date:__________