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:_____