



Orthopaedic Associates
of Central Maryland

Medical History Form

Today's Date: _____

Patient Name: _____ Date of Birth: _____
Parent/Guardian: _____ Age: _____ Gender: Male Female
Your medical doctor: _____ Specialists: _____
Referring physician: _____

Reason for visit (specify right or left): _____

Date of Onset: _____ How injury occurred: _____

Did you bring X-rays or MRI films with you? YES NO Location: _____

Are you right or left handed? (circle)

Circle pain level: NOW: 0 1 2 3 4 5 6 7 8 9 10

(0= no pain, 10 = worst pain) AT WORST: 0 1 2 3 4 5 6 7 8 9 10

What makes the pain better? _____ Worse? _____

Have you received treatment for this problem? YES NO (circle) List _____

Medications (prescription & non-prescription): list or circle NONE

Allergies to medications & reaction/side effects: list or circle NONE

Prior/current Orthopaedic problems: _____

Height: _____ Weight: _____ Age of first menstrual period or N/A: _____

Date of last menstrual period: _____ Post menopausal: YES NO (circle)

Past Medical History: check all that apply

- | | | |
|---|--|---|
| <input type="checkbox"/> congenital heart disease | <input type="checkbox"/> thyroid d/o | <input type="checkbox"/> infectious disease |
| Specify: _____ | <input type="checkbox"/> cancer, type _____ | circle: HIV AIDS |
| <input type="checkbox"/> heart attack, date _____ | date: _____ | Hep B Hep C |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> psychiatric d/o | tuberculosis |
| <input type="checkbox"/> congestive heart failure | specify: _____ | treatment: _____ |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> alcoholism | other: _____ |
| How many years _____ | <input type="checkbox"/> substance abuse | |
| <input type="checkbox"/> stroke, date: _____ | <input type="checkbox"/> blood transfusion | <input type="checkbox"/> skin problems |
| <input type="checkbox"/> high cholesterol | reason & date: _____ | specify: _____ |
| <input type="checkbox"/> adverse effect to anesthesia | <input type="checkbox"/> bleeding/clotting d/o | <input type="checkbox"/> allergies/asthma |
| Specify: _____ | specify: _____ | <input type="checkbox"/> COPD |
| <input type="checkbox"/> sleep apnea | <input type="checkbox"/> DVT/pulmonary embolism | <input type="checkbox"/> Other: _____ |
| Treatment: _____ | <input type="checkbox"/> peripheral vascular disease | |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> seizure/neurological d/o | <input type="checkbox"/> NONE apply |
| <input type="checkbox"/> osteopenia/osteoporosis | specify: _____ | |

Turn over & complete back →

Patient Name: _____

Past Surgical History: list or circle **NONE**

Date: _____ Operation/Surgeon: _____

Family History

Family member: _____ Medical problem: _____

Social History

Occupation: _____ Employer: _____
Marital Status: _____ Ethnicity: _____
Number of children/ages: _____

Tobacco Use:

Cigarettes/cigar/pipe/chew
Packs/day: _____
of years: _____
Quit? Date : _____
____Never smoked

Alcohol:

drinks/week: _____

Drugs:

Do you use drugs? YES NO
List drugs & frequency: _____
Have you used IV drugs? YES NO

Sports/activities: list with frequency or circle **NONE**

Review of Systems: check all that apply

Constitutional

___fever/chills/sweats
___unexplained weight gain/loss
___fatigue/weakness
___excessive thirst or urination

Eyes

___glasses/contacts
___change in vision

Ears/Nose/Throat/Mouth

___difficulty hearing/hearing aid
___problems with teeth/gums
___hay fever/allergies

Cardiovascular

___chest pain/discomfort
___leg pain with exercise
___palpitations/irregular heartbeat

Musculoskeletal

___muscle/joint pain

Orthopaedic problems: _____

Chest

___breast abnormalities

Respiratory

___cough/wheeze
___difficulty breathing
___sleep apnea

Gastrointestinal

___abdominal pain
___change in bowel function
___nausea/vomiting/diarrhea

Genitourinary

___incontinence
___abnormal vaginal bleeding
___vaginal/ urethral discharge

Skin

___skin problem
list: _____

Neurological

___headaches: frequency: _____
type: _____
___dizziness/light-headedness
___numbness
___memory loss
___loss of coordination/gait d/o

Psychiatric

___anxiety/stress
___depression
___sleep disorder

Blood/Lymphatic

___unexplained lymph node
___easy bruising/bleeding

Other: _____

NONE apply

The above information is accurate to the best of my knowledge.

Signature(patient or parent/guardian) _____ Date: _____