B/P: _____ (Staff use only) MRN# _____

Midwest Orthopaedic Center, SC

General Medical History Form

Name: _____ Age: _____ Date: _____

Height: _____ Weight: _____ DOB: _____ Referring Physician or Family Physician: _____

Reason for visit / injury: _____

Pain Location: _____ Severity (None 0-10 Worse): _____

When did this injury/pain begin (date)? _____ Where and how did injury occur: _____

_____

Other physicians or specialists you have visited for this problem: PCP / Family Dr:_____

Referring Physician: _____ Specialist: _____

Have you been seen by a **Cardiologist** in the past year? Name:_____ Date: _____

What testing have you received for this problem? ❑ None

❑ Plain X-Rays Date(s) _____ Where: _____

❑ CT Scan/MRI Date(s) _____ Where: _____

❑ EMG/Nerve Test Date(s) _____ Where: _____

❑ Bone Scan Date(s) _____ Where: _____

What treatment have you received for your problem? *Brace, injection, manipulation, surgery other?* _____

_____

Does any position / activity make it better? If so, what? _____

Does any position / activity make it worse? If so, what? _____

What activities do you do for fun? _____

Are you: ❑ Right Handed ❑ Left Handed

Because of this problem, I have filed or plan to file: ❑ a lawsuit ❑ a workers compensation claim ❑ neither

Is there a workers compensation dispute? ❑ Yes ❑ No

Medical History *Check all that apply* ❑ None apply

❑ Cerebral Palsy
❑ Fibromyalgia
❑ Gout
❑ Osteoarthritis
❑ Rheumatoid Arthritis
❑ Spina Bifida
❑ Heart Attack
❑ Congestive Heart Failure
❑ High Cholesterol
❑ Peripheral Vascular Disease
❑ Carotid Artery Disease, CAD
❑ High Blood Pressure

❑ Heart Murmer, Valve problems
❑ Peptic Ulcer
❑ Hepatitis
❑ Liver Disease
❑ Seizure Disorder
❑ Stroke
❑ Mini stroke / TIA
❑ Anemia
❑ Blood Clot in Leg
❑ Blood Clot in Lung
❑ Cancer Where_____
Type _____

❑ Asthma
❑ COPD, emphysema
❑ Chronic bronchitis
❑ Pulmonary Fibrosis
❑ Cystic Fibrosis
❑ Sleep Apnea
❑ Snoring
❑ Kidney Stones
❑ Kidney Disease
❑ Diabetes ❑ Type I ❑ Type II
❑ HIV, AIDS
❑ Pulmonary Hypertension
❑ Thyroid Disease
❑ Adrenal Disorder

Other Problems:

❑ Eye, Ear, Nose _____
❑ GU / Urological _____
❑ Gynecological _____
❑ Orthopaedic Fractures _____
❑ Skin _____
❑ Mental Illness _____
❑ **Other Injury or Problems** _____
_____
_____
_____
_____
_____

❑ **Implants (type/location):** _____
Can you have an MRI with these implants? ❑ Yes ❑ No

Surgical / Procedure: *Previous surgeries – List procedures, surgeon and date.* ❑ *No surgeries*

Operation	Surgeon	Date

❑ Heart or blood vessel surgery, including stents

❑ Organ Transplant Please describe _____

❑ **Poor outcomes from surgery?** Please describe _____

_____

❑ **Problems with anesthesia for your or your family?** Please explain _____

_____

Social History

1. Work status: ❑Homemaker ❑ Retired ❑ Disabled ❑ On leave ❑Unemployed ❑Full-time ❑Part-time

Occupation: _____ Employer_____ Date last worked _____

2. Education: ❑ GED ❑High School ❑ Associates ❑ Bachelors ❑ Masters ❑ Doctorate ❑ Other: _____

3. Marital status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Partner/Significant Other ❑ Co-Habitating

4. Tobacco use: ❑ Never (skip to #5) ❑ Cigar ❑ Chew ❑ Pipe ❑ E-Cig/Vape

❑ Cigarettes ____ packs per day for _____ years.

❑ Quit? When? _____ *Date* after smoking _____ packs per day for _____ years.

5. Alcohol: ❑ Never or rare ❑ Drinks/week_____ ❑ Recovering alcoholic ❑ History of Alcohol Rehab

6. Drug use: ❑ Never ❑ Currently ❑ In the past ❑ Recovering Addict

7. ❑ **Flu Shot:**_____ Month / Year ❑ **Pnuemonia Shot** _____ Month / Year

8. Do you have any religious beliefs or values that we need to know about to help us with your care? ❑ No ❑ Yes

Please list _____

Family History: Check all that apply | *Note mother, father, sibling* ❑ *No significant family history*

❑ Alcoholism _____ ❑ Cancer _____ ❑ Heart Disease _____ ❑ Scoliosis _____

❑ Arthritis _____ ❑ Diabetes _____ ❑ Hypertension _____ ❑ Seizures _____

❑ Asthma _____ ❑ Depression _____ ❑ Kidney Disease _____ ❑ Stroke _____

❑ Bleeding Disorders _____ ❑ Gout _____

❑ Other: _____

Are you adopted? ❑ Yes ❑No **Parents deceased?** ❑ No Yes: ❑Mother ❑Father

Allergies & Reaction

(*Rash or Swelling • Wheezing or shock * Upset stomach * Unknown reaction}*

❑ No Allergies

Do you have a Latex allergy? ❑ Yes ❑ No

List of medications and dose taken

(Include all over-the-countermedications) ❑ *Not taking any medication*

Medication name	Dose	How often?	Medication name	Dose	How often?

Review of Systems: *Check all that apply* ❑ *None apply*

- ❑ Reading glasses
- ❑ Change of vision
- ❑ Eye disease
- ❑ Loss of hearing
- ❑ Ear pain
- ❑ Hoarseness
- ❑ Nosebleeds
- ❑ Difficulty swallowing
- ❑ Morning cough
- ❑ Dizziness
- ❑ Congestion
- ❑ Sore throat
- ❑ Toothache, tooth problems
- ❑ Gum trouble/bleeding gums
- ❑ Mouth/throat ulcers
- ❑ Bruise easily
- ❑ Prolonged bleeding
- ❑ Heart or chest pain
- ❑ Abnormal heartbeat
- ❑ Swollen ankles, legs
- ❑ Calf cramps with walking
- ❑ Shortness of breath at rest
- ❑ Shortness of breath with exertion
- ❑ Pneumonia
- ❑ Heart disease
- ❑ Heart burn
- ❑ Poor appetite
- ❑ Nausea or vomiting
- ❑ Stomach pain
- ❑ Ulcers
- ❑ Frequent belching
- ❑ Frequent diarrhea
- ❑ Frequent constipation
- ❑ Hemorrhoids
- ❑ Frequent urination
- ❑ Burning on urination
- ❑ Difficulty starting urination
- ❑ Get up more than once every night to urinate
- ❑ Difficulty holding urine
- ❑ Joint pain
- ❑ Frequent headaches
- ❑ Night sweats
- ❑ Numbness or tingling sensation
- ❑ Heat or cold intolerance
- ❑ Blackouts
- ❑ Seizures
- ❑ Use more than one pillow or wake up short of breath
- ❑ Frequent rash/skin eruptions
- ❑ Itching
- ❑ Moles
- ❑ Abnormal nails
- ❑ Fever or chills
- ❑ Hot or cold spells
- ❑ Fainting
- ❑ Weakness
- ❑ Loss of coordination
- ❑ Recent weight change
- ❑ Eating disorder
- ❑ Nervous exhaustion
- ❑ Depression
- ❑ Anxiety
- ❑ Bipolar
- ❑ Schizophrenia
- ❑ Other: _____

Physician Signature _____ Date: _____ Time: _____