

CHARLESTON ORTHOPAEDIC ASSOCIATES
MEDICAL HISTORY FORM

NAME: _____ DATE: _____

New Patient Updating Patient

Height: _____ Weight: _____ Age: _____ BMI: _____
(Dr. Friedman to complete)

Chief Complaint – Why are you being seen today? _____

ALLERGIES

Please list your allergies below

- NONE Codeine Aspirin Novocaine Iodine Penicillin Sulfa Latex
 Adhesive Tape Shellfish Others: (please list all): _____

MEDICATIONS

Please list all your medications. Include non-prescription medicines and supplements

- NONE Coumadin Plavix Daily Aspirin Celebrex Bextra Mobic Vitamin E
 Ticlid Motrin Aleve Others (please list all): _____

MEDICAL ILLNESS

Please indicate any medical problems you have below

- NONE High Blood Pressure Reflux Heart Disease Stroke Liver Disease Asthma Diabetes
 Kidney Disease Thyroid Disease Stomach Ulcers Blood Clots in Legs
 Cancer type: _____ Arthritis in joint(s): _____
 Other: _____

SURGICAL HISTORY

Please indicate any surgeries you have had and their location

- NONE Heart Bypass Appendectomy Gall Bladder Removal Hysterectomy Heart Catheterization
 Fracture Surgery _____ Arthroscopy _____
 Joint Replacement _____ Spine Surgery _____
 Other: _____

FAMILY HISTORY

Please check any problem below that runs in your family

- Heart Disease Diabetes High Blood Pressure Bleeding Problems Osteoporosis
 Cancer type: _____ Arthritis joint(s): _____
 Other: _____

SOCIAL HISTORY

Please provide the following information

FAMILY OR MEDICAL DOCTOR : _____

Do you smoke? No Yes # packs per day _____ Do you drink alcohol? No Yes # drinks per day _____

Occupation: Retired Other (job title, type of work you do): _____

Marital Status: Married Single Separated Divorced Widowed Could you be pregnant? No Yes

REVIEW OF SYSTEMS

Please indicate if you have any of these problems

- Headaches Cough Wheezing Chest Pain Indigestion Burning with Urination Anxiety
- Numbness Weakness Seizures Problems Sleeping Depression Fever Joint Pains
- Jaundice Skin Problems Fainting Swelling of Hands Shortness of Breath Chills
- Change in bowel or Bladder Habits Swelling of Feet Unexplained Pain Bleed Easily Vision Problems
- Others not listed: _____

WHAT PROBLEM ARE YOU HERE TO SEE THE DOCTOR FOR TODAY:

<input type="checkbox"/> Hip <input type="checkbox"/> Thigh <input type="checkbox"/> Knee <input type="checkbox"/> Calf <input type="checkbox"/> Ankle <input type="checkbox"/> Foot	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	<input type="checkbox"/> Shoulder <input type="checkbox"/> Arm <input type="checkbox"/> Elbow <input type="checkbox"/> Forearm <input type="checkbox"/> Wrist <input type="checkbox"/> Hand	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	<input type="checkbox"/> Neck <input type="checkbox"/> Upper Back <input type="checkbox"/> Lower Back <input type="checkbox"/> Pelvis <input type="checkbox"/> Chest or Ribs
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WHEN DID YOUR PROBLEM START: Enter Date: ____/____/____ or #____ Days Weeks Months Years

DID THIS PROBLEM START WITH AN INJURY OR ACCIDENT? No Yes If yes, Date of accident: ____/____/____

DID YOUR ACCIDENT OCCUR AT: Work Motor Vehicle Other: _____

Briefly describe how your accident or injury occurred: _____

On a scale of 1 to 10 with 10 being the worst pain imaginable, how SEVERE is your pain: _____

Time of day or night the pain is at its worst: _____

What makes the problem WORSE: _____

What makes the problem BETTER: _____

Prior treatment for this problem? No Yes When _____

If yes, what doctor(s) treated you for it? _____

Were x-rays, MRI scan, or any other tests done or taken? No Yes Where: _____

Have you had SURGERY for this problem before? No Yes - Date: _____

If yes, what type of surgery? _____

Have you been to Physical Therapy for this problem? No Yes - Date: _____

Any other information regarding your problem: _____