FLATHEAD ORTHOPEDICS

Medical History Form

Patient Name:_____ DOB:_____ Height:_____ Weight:_____

Currently Pregnant: □ Yes □ No □ Possible Dominant Hand: □ Left □ Right

Reason for Visit	Onset Date
1.	
2.	

Known Medication Allergies: □ Yes (Please Specify Below) □ No	Reaction/Severity
1.	
2.	
3.	
Current Medications/Supplements:	**Dosage:**
1.	
2.	
3.	
4.	
5.	

Review of Systems: (check box if symptom applies to you)

Constitutional
- □ Chills
- □ Fatigue
- □ Fever
- □ Night Sweats
- □ Weight Gain
- □ Weight Loss

Ear, Nose, Throat
- □ Headache
- □ Ringing in Ears
- □ Vertigo

Respiratory
- □ Asthma
- □ Cough
- □ Shortness of Breath
- □ Recent Infections
- □ Wheezing

Cardiovascular
- □ Chest Pain
- □ Heart Murmur
- □ Leg Swelling
- □ Irregular Heartbeat or Palpations

Gastrointestinal
- □ Abdominal Pain
- □ Heartburn
- □ Jaundice
- □ Loss of Appetite
- □ Nausea
- □ Vomiting

Urinary System
- □ Frequent Urination
- □ Urinary Incontinence

Metabolic / Endocrine
- □ Cold Intolerant
- □ Heat Intolerant

Neurology
- □ Difficulty Walking
- □ Dizziness
- □ Poor Coordination
- □ Memory Loss
- □ Seizures

Psychiatric
- □ Anxiety
- □ Depression

Skin
- □ Contact Allergy
- □ Rash
- □ Skin Infections
- □ Skin Lesions

Musculoskeletal
- □ Negative, Except as noted in HPI

Hematologic
- □ Bleeding
- □ Bruising

Allergies
- □ Bee Stings
- □ Environmental
- □ Food (Specify)

Medical History

□ Alzheimer's	□ High Cholesterol	□ Kidney Disease
□ Anemia	□ Fibromyalgia	□ Scoliosis
□ Angina	□ Fracture (Specify)_____	□ Seizure Disorder
□ Arthritis	□ Gout	□ Sleep Apnea
□ Asthma	□ Headache/Migraine	□ Spinal Stenosis
□ Cancer (Specify)_____	□ Hepatitis A B C	□ Spondyloarthropathy
□ Congestive Heart Failure	□ High Blood Pressure	□ Stroke
□ COPD	□ Inflammatory Bowel Disease	□ Systemic Lupus Erythematosus
□ Coronary artery Disease	□ Lyme Disease	
□ Crohn's Disease	□ Heart Attack	□ Thyroid Disease
□ Deep Venous Thrombosis	□ Obesity	□ Valvular Disease
□ Degenerative Joint Disease	□ Osteoporosis	□ Other:
□ Depression	□ Parkinson Disease	_____
□ Diabetes	□ Peptic Ulcer Disease	
□ Drug Abuse	□ Psoriasis	

Surgical History

Please circle the correct side if applicable

			Year		
□ ACL Repair	R	L	_____		**Year**
□ Carpal Tunnel Release	R	L	_____	□ Angioplasty	_____
□ Cataract Extraction	R	L	_____	□ Appendectomy	_____
□ Knee Replacement	R	L	_____	□ Back Surgery	_____
□ Meniscus Surgery	R	L	_____	□ Blood Transfusion	_____
□ Knee Arthroscopy	R	L	_____	□ CABG	_____
□ Hip Replacement	R	L	_____	□ Cardiac Pacemaker	_____
□ Hip Arthroscopy	R	L	_____	□ Cardiac Valve Replacement	_____
□ Rotator Cuff Repair	R	L	_____	□ Colectomy	_____
□ Shoulder Arthroscopy	R	L	_____	□ Colostomy	_____
□ Ankle Arthroscopy	R	L	_____	□ Cesarean	_____
□ Elbow Arthroscopy	R	L	_____	□ Gastric Bypass	_____
□ Wrist Arthroscopy	R	L	_____	□ Gallbladder Removal	_____
□ Mastectomy	R	L	_____	□ Hernia Repair	_____
				□ Hysterectomy	_____
□ Amputation (specify) _____				□ Small Bowel Resection	_____
				□ Thyroidectomy	_____
				□ Tonsillectomy	_____

Other: _____

Family History

Diagnosis	Relation	Diagnosis	Relation
□ ADD/ADHD		□ Genetic Disease	
□ Alcoholism		□ Gout	
□ Allergies		□ Hearing Impairment	
□ Alzheimer's Disease		□ High Blood Pressure	
□ Arthritis		□ Learning Disability	
□ Asthma		□ Liver Disease	
□ Blood Disorder		□ Mental Illness	
□ Cancer: Specify		□ Migraines	
□ Cardiovascular Disease		□ Muscle Disease	
□ Colitis		□ Obesity	
□ Congenital Heart Disease		□ Osteoporosis	
□ Congestive Heart Failure		□ Parkinson's Disease	
□ COPD		□ Peripheral Vascular Disease	
□ Coronary Artery Disease		□ Renal Disease	
□ Depression		□ Seizure Disorder	
□ Developmental Delay		□ Stroke	
□ Diabetes		□ Thyroid Disorder	
□ Drug Abuse		□ Other:	
□ High Cholesterol			

Social History

Alcohol Intake: □ Yes □ No

□ Daily

□ Weekly

□ Monthly

Activity Level: Low Medium High

(*circle one of the above*)

Type of Exercise:_____ **How Often:**_____

Occupation:_____

Tobacco Usage:

Cigarettes:	□ Current	□ Previous	□ Never
Cigars:	□ Current	□ Previous	□ Never
Smokeless Tobacco:	□ Current	□ Previous	□ Never

Packs per day:_____ Years:_____ Tried to Quit? □ Yes, When?_____ □ No

Preferred Pharmacy:_____

Pharmacy Location:_____

Primary Care Physician:_____

Employer:_____

I have read and filled out the above medical history form to the best of my knowledge, knowing that information incorrectly documented could have an adverse effect on my medical treatment

_____

Patient Signature Date