



PATIENT MEDICAL HISTORY

1. Print From 2. Fill-in, Sign and Date Form 3. Fax, Email or Bring to your appointment

New Patient Established Patient Account# _____

Is your visit related to an automobile or on the job injury? Yes No

Name _____ Age _____ Height _____ Weight _____

Single Married Divorced

Referring Doctor _____

Past Medical History (✓ All that apply)

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Drug addiction | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Hearing impaired | <input type="checkbox"/> Hard of hearing |
| <input type="checkbox"/> HIV positive | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Neurologic disease | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Pregnant (current) | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Stomach ulcers | <input type="checkbox"/> Seizure disorder | <input type="checkbox"/> Sexually transmitted disease | |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Other _____ | |

Occupation

Working Not working Unemployed Retired

Smoke

None Reformed # of years _____ Social Smokes # of packs daily _____

Alcohol

None Social Moderately Daily

Cardiovascular

Chest pain Blood clot Poor circulation

Surgeries in the Past (Please list all)



Prescription Medications (Please list all)

Over-the-counter Medications (Please list all)

Medications I Am Allergic to (Please list all)

Family History Illness of Family Members

Immunization/date

Tetanus/Date Hepatitis/Date TB/Date

Past Orthopaedic History (✓ All that apply)

Arthritis Rheumatoid arthritis Bone fracture Musculoskeletal injury
 Gout Inflamed/infected joint

Review of systems (✓ All that apply)

Constitutional: Recent weight loss Generalized weakness Fever
Eyes, Ears, Nose & Throat: Frequent nosebleeds Seasonal allergies
Respiratory: Cough/wheeze Shortness of breath
Skin: Rash Itching
Gastrointestinal: Intestinal bleeding Heartburn Unable to control bowels
Genitourinary: Painful urination Frequent urination Unable to control urination
Neurologic/psychiatric: Arm weakness/numbness Leg weakness/numbness Anxiety
Cardiovascular: Chest pain Blood clot Poor circulation
Hematologic: Excessive bruising Blood thinner Rx
Past musculoskeletal history:
 Joint Pain Joint swelling Joint stiffness
 Extremity pain Extremity weakness

Sign _____

Date _____

Print, complete and fax/email to:
 Fax: (504) 899-7317 • Email: Main@southern-ortho.com

