Orthopedic Sports Medicine & Spine Care Institute

Medical History Form
For Andrew M. Wayne, M.D.

Please fill out completely due to this being part of your permanent medical record.

Name: _____ Sex: M/F Date: _____

Date of Birth: _____ Height: _____ Weight: _____ Age: _____

Who referred you to our office? _____

Description of current employment (or most recent job): _____

How long have you been at this job? _____

If not working, date last worked: _____ Is injury work-related? ____ Yes ____ No

If work injury, are you now working Full Duty _____ Light Duty _____ Off Work _____

Describe the injury or disorder and any related symptoms: _____

_____

_____

What date did it begin? _____

How did it occur? _____

_____

_____

Have you ever injured or had problems with this body part before? _____ Yes _____ No

If yes, explain: _____

What treatment has been done for this current condition? (Circle all that apply)

Surgery (specify) _____

Physical Therapy (General start and end dates) _____

Injection(s) (specify) _____

Medications (which ones) _____

Chiropractic (general start and end dates) _____
Massage
Brace/cast

Other _____
Health problems (not surgeries):

_____

_____

Past Surgical History: (Please list year of surgery)

_____

_____

Please list any diagnostic studies you have had for this condition (date & place)
X-rays: _____

MRI: _____

Cat scan: _____

EMG/Nerve conduction study: _____

Blood test (s): _____

Other: _____

List Allergies to medication (s) None or list: _____ Latex Y ____ N ____

_____ Iodine Y ____ N ____

Please list all Current Medications: (include doses if you know)

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

Social History: Do you live with someone that can help you? Y _____ N_____

Marital Status: Married / Single / Divorced / Widowed

Alcohol Y____ N ____ Occasional ____ Moderate ____ Heavy ____

History of alcohol abuse Y____ N ____ History of Drug abuse ____Y ____N

Tobacco Y ____N ____ Years used ____ Packs per day ____ Recreational drug use Y____ N ____

Do you use a cane, walker or wheelchair? Y____ N ____ (Circle which one if it applies.)

Family Medical History: (Circle all that apply)

Stroke	Diabetes	Seizures	Cancer
Heart disease	Arthritis	Mental illness	Bleeding disorder
High blood pressure	Gout	Kidney disease	Alcoholism

Other Illness _____

_____

Review of Systems: Please check all that apply:

General

___Weight Change
(__Gain ___Loss)
___ Fever
___ Chills
___ Night Sweats
___ Fainting
___ Bleeding Disorder
___ Lumps (Location)
___ Dizziness
___ Itching
___ Rash
___ Diabetes Mellitus
___ Thyroid Problems
___ Cancer (Specify)
_____

Ear – Nose – Throat – Eye

___ Visual Change
___ Hearing Change
___ Ringing in Ears
___ Dentures
___ Bleeding Gums
___ Hoarseness
___ Vertigo

Musculoskeletal

___ Neck Pain
___ Mid Back Pain
___ Low Back Pain
___ Joint Pain
___ Joint Swelling
___ Osteoporosis
___ Broken Bone (Specify)
_____

Cardiovascular

___ Heart Disease
___ Chest Pain
___ High Blood Pressure
___ Mitral Valve Prolapse
___ Vein Problem
___ Swelling in legs
___ Blood Clot
___ High Cholesterol
___ Rheumatic Fever
___ Pacemaker
___ Rapid or Irreg. Heartbeat

Respiratory

___ Cough (dry, productive)
___ Tuberculosis
___ Sinus Congestion
___ Pneumonia
___ Shortness of Breath
___ Asthma
___ Chronic Lung Disease

Genitourinary

___ Urinary tract infection
___ Incontinence
Circle (bowel/bladder)
___ Venereal Disease
___ Menopause
___ Frequent Urination
___ Kidney Stone
___ Kidney Disease

Breast

___ Lumps
___ Pain
___ Discharge

Neurologic

___ Seizures (Most Recent)
_____
___ Headache
___ Numbness
Circle Arms / Legs
___ Weakness
Circle Arms / Legs
___ Concussion
___ Memory Loss
___ Pain shooting down arms
Circle Right Left
___ Pain shooting down legs
Circle Right Left

Psychiatric

___ Depression
___ Anxiety
___ Bipolar Disorder
___ Schizophrenia

Gastrointestinal

___ Diff. Swallowing
___ Nausea
___ Vomiting
___ Jaundice
___ Hepatitis
___ Ulcer Disease
___ Diarrhea
___ Constipation
___ Acid Reflux
___ Liver Disease

Other not listed above: _____

I hereby acknowledge by signing this sheet that all of the information is complete and accurate.

Signature _____ Date _____

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PHYSICAL HISTORY EXAMINATION

Name: _____ Date: _____ Chart#: _____

Age: _____ Height: _____ Weight: _____ Pregnant? ____Y ____N

Referring Doctor: _____ Phone: _____

PAIN INTENSITY RATING

On the line below, CIRCLE your AVERAGE PAIN over this last week.

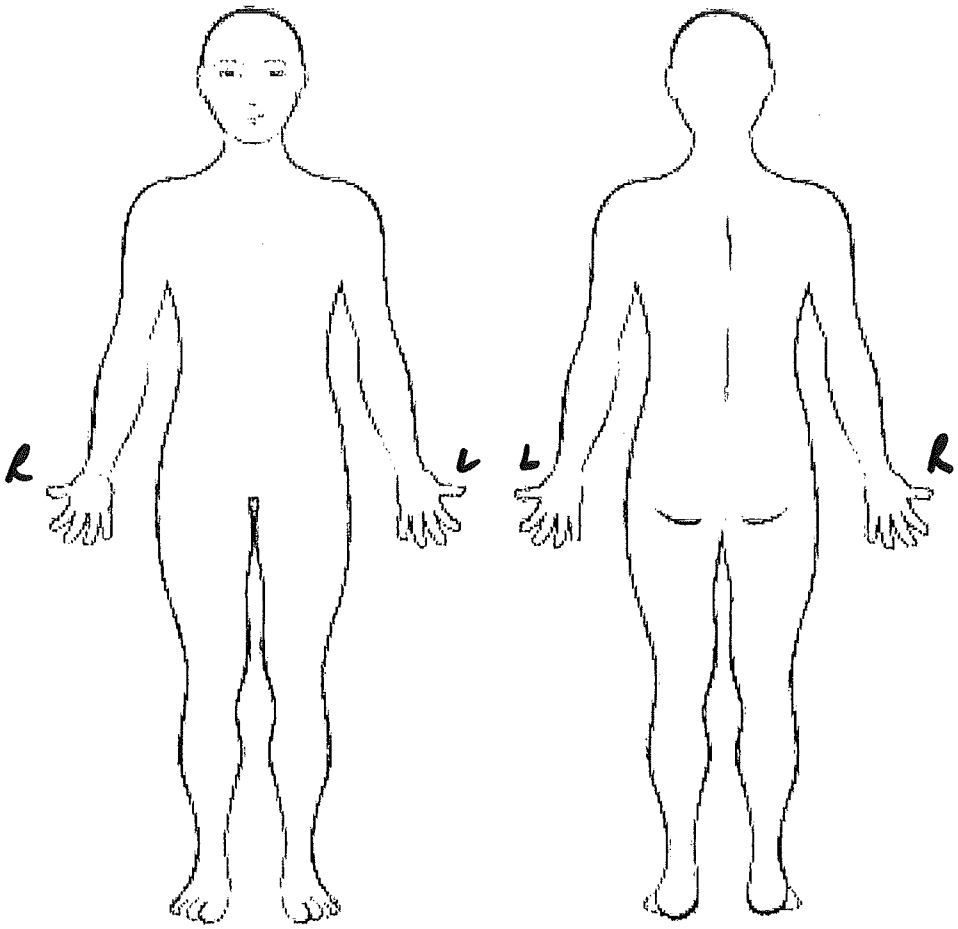
No Pain — Worst Possible

0% 10 20 30 40 50 60 70 80 90 100

WHERE IS YOUR PAIN NOW?

Use appropriate symbols shown below to mark the areas on your body where you feel these described sensations. Include ALL areas affected by your pain, and mark the type and area of pain if it radiates or spreads to other areas.

Burning X	Numbness O	Pins/Needles =	Stabbing /	Ache Λ



Physician Initials _____ Date _____