

Orthopedic Sports Medicine & Spine Care Institute
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MEDICAL HISTORY FORM

Name: _____ Date: _____ Age: _____ Sex _____ Chart: _____

Height _____ Weight _____ Recent increase or decrease _____ Left or Right-handed _____

Part of body affected _____

Quality of discomfort: Intermittent Constant Other _____

Type of discomfort: Severe Moderate Mild Other _____

DURATION: How long has this been a problem _____ Date of injury (if applicable) _____

Please circle the activities that make pain worse:

Sitting	Standing	Lying	Walking	Lifting	Bending
Coughing	Sneezing	Stairs	Pushing	Pulling	Other _____

Please list any activities that make your pain less _____

Does your pain interfere with sleep? _____ Does your pain wake you up from a sound sleep? _____

Has any other treatment helped control your symptoms? _____

If problem(s) with shoulder, elbow, wrist, hand, hip, knee, ankle or foot only: _____

Does the joint (please circle) catch lock or seize up swell pop
snap grind shift pop out of joint give out

If problem(s) are with back or neck only. Does pain radiate into legs (back) _____ arms(neck) _____

Do you have numbness: Lt leg Rt leg Lt arm Rt arm

Do you have weakness: Lt leg Rt leg Lt arm Rt arm

Loss of Control: urination defecation erection

Has ability to walk distances been limited? _____ Distance you can walk before having to stop _____

Review of Systems: (recent or current conditions):

Weight change	Hearing Changes	Shortness of Breath	Urinary Bleeding
Fever/Chills	Ear Pain/Ringing	Cough	Frequent Headaches
Night Sweats	Nosebleeds	Nausea/Vomiting/Seizures	Numbness
Poor Appetite	Hoarseness	Stomach Pain	Weakness
Rash	Difficulty Swallowing	Frequent Diarrhea	Backache
Insomnia	Tooth/Gum Trouble	Frequent Constipation	Musculoskeletal
Depression	Chest Pain	Blood in Stool	Joint/Limb Pain/Swelling
Anxiety	Abnormal Heartbeat	Incontinence	Lump/Masses
Visual Changes	Blackouts	Urinary Frequency	Woman only: Pregnant

If you circled any of the above, please explain: _____

Past Medical History:

Hypertension (high blood pressure)	Y	N
Elevated Cholesterol	Y	N
Arthritis	Y	N
Diabetes	Y	N
Heart Disease	Y	N
Cancer	Y	N
Other:	_____	

Past Surgical History: (please indicate each procedure and year performed)

Medications: Name/Dosage

Allergies: _____

Social History:

Are you now or have you ever been treated for an emotional or psychological order? _____

Do you smoke? Y N Packs/Day _____

Do you consume alcohol? Y N Amount/Day _____

Recreational drug use? Y N Amount _____

Marital Status (please circle) Single Married Divorced Separated Widowed

Employment status (list/describe job if employed) _____

Referred by: _____

Who is your primary care physician? _____

Family History:

Hypertension	Mother	Father	Sibling	Grandparent
Cancer	Mother	Father	Sibling	Grandparent
Diabetes	Mother	Father	Sibling	Grandparent
Arthritis	Mother	Father	Sibling	Grandparent
Heart Disease	Mother	Father	Sibling	Grandparent

Other: _____

List all diagnostic studies you have had for this condition along with date and place the study was performed. (X-ray, MRI, Myelogram, CT Scan, Bone Scan, EMG/NCV, etc.)

1. _____ 3. _____

2. _____ 4. _____

Patient Signature _____ Date: _____