Sherwyn J. Wayne, M.D.

Medical History Form

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

Name: _____ Date: _____ SSN: _____-_____-_____

Please Circle: Mr. Mrs. Ms. Dr. Rev. Sr. Pregnant: Y / N Age: _____ Birthdate: _____

Right / Left Handed: _____ Date of Accident/Injury: _____ Name of Spouse: _____

Telephone Numbers: Home ( )_____-_____ Work ( )_____-_____

Drug *Allergies:* _____ Height: _____ Weight: _____

Chief Complaint: _____

Please describe the recent events of this current orthopedic problem. Answer how long it has been a problem, what makes it worse, and what makes it better:_____

_____

_____

Please list all Current Medications:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Past Surgeries: Please list in chronological order from oldest to newest year of surgery.

1. _____ 3. _____
2. _____ 4. _____

List any diagnostic studies you have had for this condition along with date and place the study was performed. (MRI, CAT Scan, X-rays, EMG, NCV etc.):

1. _____ 3. _____
2. _____ 4. _____

Family Medical History: List medical illnesses affecting your immediate family, i.e., parents/siblings.

Disease	Family Member	Disease	Family Member
1. _____		3. _____	
2. _____		4. _____	

Orthopedic Sports Medicine & Spine Care Inst.

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Social History: Check and fill in the blanks.

____Married	____Single	____Divorced	____Live Alone	#____ Children #____Pets
____Alcohol	____Occasional	____Moderate	____Heavy	____History of Abuse
____Tobacco	____Years used	____Packs per day	____Recreational Drugs	____Years used

General History: Please check if any apply

General
____1. Weight change
____2. Fever or chills
____3. Night Sweats
____4. Urinary frequency
____5. Bleeding
____6. Lumps or masses
____7. Dizziness or fainting
____8. Itching or rash
____9. Diabetes Mellitus
____10. Thyroid problem
____11. Cancer

Ear-Nose-Throat-Eye
____1. Visual change
____2. Hearing change
____3. Tinnitus
____4. Dentures
____5. Bleeding gums
____6. Hoarseness

Gastrointestinal
____1. Dysphagia (difficulty Swallowing)
____2. Nausea & vomiting
____3. Jaundice
____4. Hepatitis

Cardiovascular
____1. Heart dx/pain
____2. Hypertension
____3. Mitral valve prolapse
____4. Thrombophlebitis

Respiratory
____1. Cough/Sputum
____2. Rheumatic fever
____3. Tuberculosis
____4. Pleurisy/pneumonia
____5. Shortness of breath
____6. Asthma

Genitourinary
____1. Urinary tract infection
____2. Incontinence
____3. Venereal diseases
____4. Menopause

Neurologic
____1. Seizures
____2. Paralysis
____3. Numbness
____4. Weakness

Musculoskeletal
____1. Backache
____2. Joint pain
____3. Numbness

Breast
____1. Lumps, pain, discharge

Other medical conditions not listed above:
1._____ 2._____

Description of current employment/Occupation:
_____

Is injury work related? _____Yes _____No

Who referred you to this office?_____

Name of Primary Care Physician: _____