# MEDICAL HISTORY FORM

**TODAY'S DATE:**

## PATIENT INFORMATION

| | | |
|---|---|---|
| **PATIENT NAME:** | | **DATE OF BIRTH:** |
| **AGE:** | **HEIGHT:** | **WEIGHT:** |
| **REFERRING PHYSICIAN:** | **REASON FOR VISIT (INCLUDE BODY PART AND RIGHT OR LEFT SIDE):** | |
| **INJURY DATE:** | **WORK RELATED:** ☐ YES ☐ NO | **REPORTED TO EMPLOYER:** ☐ YES ☐ NO |
| **ATTORNEY NAME:** | | |

## SYMPTOMS

**DESCRIBE SYMPTOMS:**

**SYMPTOMS ARE:** ☐ MILD ☐ MODERATE ☐ SEVERE

**SYMPTOMS ARE:** ☐ CONSTANT ☐ INTERMITTENT

**OTHER SYMPTOMS ASSOCIATED TO THIS INJURY:**

☐ None ☐ Fever ☐ Chills ☐ Weight Loss ☐ Tingling ☐ Numbness ☐ Swelling ☐ Locking ☐ Giving Way

**WHEN DID THESE SYMPTOMS BEGIN?**

**WHAT MAKES YOU FEEL BETTER?**

**WHAT MAKES YOU FEEL WORSE?**

**Which Tests Have You Had in the Last Four (4) Months in Regards to Your Current Injury? (Check All That Apply)**

☐ Blood Work ☐ X-Rays ☐ MRI ☐ CT Scan ☐ EMG ☐ Bone Density ☐ Bone Scan

**FACILITY/HOSPITAL:** **DATE:**

## HEALTH PROBLEMS

**CHECK ALL OF THE HEALTH PROBLEMS YOU HAVE HAD:**

| | | | |
|---|---|---|---|
| ☐ Diabetes | ☐ Heart Disease | ☐ High Blood Pressure | ☐ Shortness of Breath |
| ☐ Stroke | ☐ Lung Disorder | ☐ Sleep Apnea | ☐ Bowel Problems |
| ☐ Hepatitis | ☐ Depression | ☐ Neurological Disorder | ☐ Bladder Problems |
| ☐ HIV | ☐ Asthma | ☐ Weight Gain/Loss | ☐ Chest Pains |
| ☐ Cancer | ☐ Anemia | ☐ Bleeding Problems | ☐ Headache |
| | | | ☐ High Cholesterol |

☐ OTHER _____

**CHECK ALL OF THE SURGERIES YOU HAVE HAD:**

| | | | |
|---|---|---|---|
| ☐ Joint Surgery | ☐ Hysterectomy | ☐ C-Section | ☐ Heart Disease |
| ☐ Spine Surgery | ☐ Appendectomy | ☐ Gallbladder | ☐ Tonsillectomy |

☐ OTHER _____

# PINNACLE ORTHOPAEDICS MEDICAL HISTORY FORM CONTINUED

## FAMILY HISTORY

**CHECK ALL HEALTH PROBLEMS BLOOD MEMBERS OF YOUR FAMILY HAVE HAD AND LIST THE RELATION:**

☐ Arthritis _____ ☐ Osteoporosis_____

☐ Cancer _____ ☐ Diabetes _____

☐ Scoliosis _____ ☐ Heart Disease _____

☐ Stroke _____ ☐ Bleeding Disorder_____

☐ Blood Clots _____ ☐ Hypertension _____

☐ OTHER _____

## SOCIAL HISTORY

DO YOU SMOKE? ☐ YES ☐ NO

NUMBER OF PACKS PER DAY: _____

DO YOU DRINK ALCOHOL? ☐ YES ☐ NO

NUMBER OF DRINKS PER DAY: _____

HAVE YOU EVER BEEN – OR ARE YOU CURRENTLY BEING – TREATED FOR ABUSE OF ALCOHOL, ILLEGAL DRUGS, OR PRESCRIPTION DRUGS? ☐ YES ☐ NO

## MEDICATIONS

**LIST THE NAMES, DOSAGE AND FREQUENCY OF ALL MEDICATIONS YOU ARE CURRENTLY TAKING:**

| MEDICATION | DOSAGE | FREQUENCY |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## ALLERGIES

**LIST THE NAME(S) OF ANY DRUG(S) YOU ARE ALLERGIC TO AND THE REACTION YOU HAVE TO THE DRUG(S) WHEN TAKEN:**

_____

_____

_____

☐ **LATEX ALLERGY**

## DO NOT WRITE BELOW THIS LINE – FOR OFFICE USE ONLY:

PHYSICIAN REVIEW: _____ DATE: _____