UC Health
Orthopaedics & Sports Medicine

PATIENT MEDICAL HISTORY

Name: _____ **Social Security No.:** _____

Birth Date: _____ **Age:** _____ **Gender: M** ____ **F** ____ **Occupation:** _____

Primary Care Physician: _____ **Referred By:** _____

Are you currently working? Yes ____ **No** _____ **Where do you work?** _____ **How long?**_____

Name of School Attending: _____ **Grade:** _____

Briefly describe the main reason for your visit: _____

_____

_____

Is this problem the result of an accident/injury? Yes ____ **No** ____ **Did the accident occur at work? Yes** ____ **No**_____

Date of injury: _____ **Days off work:** _____ **BWC Claim #:** _____

Work Status/Restrictions:_____ **Attorneys Name:**_____

Please list your current medications, including Aspirin, Tylenol, Ibuprofen and other over the counter medications.

Name of Medicine	Dosage		Name of Medicine	Dosage

Allergies? Yes_____ **No**_____ **If yes please list:**_____

Have you ever been hospitalized? Yes _____ **No** _____ **Had an operation? Yes** ____ **No**_____

Please list all hospitalizations and operations: _____

_____

_____

_____

_____

_____

_____

_____

Social History: Do you smoke? _____ **Packs/day:** _____ **# of Years:** _____ **Do you drink?** _____ **Amt./day:**_____

Patient Name:_____**DOB:**_____

PLEASE INDICATE BELOW WHICH HAVE BEEN PAST MEDICAL PROBLEMS FOR YOU

	Yes	No		Yes	No
Heart disease			Blood clots in your legs, lungs		
High blood pressure (Hypertension)			Neurological disease		
Lung disease (see below):			Have you ever had a stroke?		
Bronchitis			Do you have seizures?		
Emphysema			Cancer		
Asthma			Osteoporosis		
Diabetes			Osteoarthritis, degenerative arthritis		
Ulcer or stomach disease			Rheumatoid arthritis		
Kidney or bladder disease			Other medical problems, please specify:		
Liver disease					
Anemia or any blood disease					

DO YOU HAVE ANY PROBLEMS WITH ANY OF THE ITEMS BELOW? (Please answer Yes or No)

NEUROLOGIC

Thinking Clearly_____

Walking_____

Weakness_____

Seizures_____

Dizziness_____

CARDIAC AND PULMONARY

Chest Pain_____

Palpitations_____

Shortness of breath_____

Heart disease_____

Other_____

UROGENITAL

Incontinence_____

Retention_____

Urgency_____

Sexual dysfunction_____

Sexual disease_____

Other_____

MUSCULOSKELETAL

Arthralgias_____

Pain_____

Swelling_____

Limited motion_____

PSYCHIATRIC

Illness_____

Sleep disturbance_____

GASTROINTESTINAL

Constipation_____

Other_____

HEENT

Glasses_____

Visual change_____

Hearing change_____

ENDOCRINE

Diabetes_____

Thyroid disorder_____

CONSTITUTIONAL

Weight loss_____

CANCER HISTORY_____

BLOOD DISORDER/VASCULAR_____

FAMILY HISTORY_____

_____

Your current height: _____ **Feet** _____**Inches** **Your current weight:** _____ **pounds**

Patient Signature: _____ **Date:** _____

BP: _____/_____ **Heart Rate:** _____ **Respiratory Rate:** _____ **Temperature:** _____

Physician Signature: _____ **Date:** _____