

Date _____

Upper Bucks Orthopaedics Medical History Form

Name: _____ DOB: _____ Age: ____ Ht: ____' ____" Wt: _____

Circle: Male/ Female

Family Physician _____ Referring Physician _____

Reason for Visit (Main Problem):

Did your injury occur at work? Yes No In a motor vehicle accident? Yes No

Is there currently litigation (a legal case) related to your injury active at this time? Yes No

Current Medications: Please list ALL medications which you take including over the counter, vitamins and herbal supplements (Dosage and frequency):

Medication Allergies: Yes No (Please list, also include the reaction to the medication):

Other Allergies: Yes No (Please list any non-medication allergies – i.e. foods, latex, etc.)

Social History:

Occupation: _____

Do you use tobacco – past or present? Yes No (type, #packs per day, # of years)

Do you use alcohol? Yes No Circle amount: Rare (holidays), Occasional (1-2 per week), Moderate (1-2 per day), Heavy (3+ per day)

Family History: Any family members with heart disease, diabetes, rheumatoid arthritis, anesthesia problems, bone cancer? (please circle)

Surgery: (types of surgery, approximate date, any complications)

YOUR MEDICAL HISTORY

DO YOU CURRENTLY HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

	YES	NO		YES	NO
Anesthesia Reaction			Heart Disease		
Rheumatoid Arthritis			Heart Murmur		
Bleeding Disorder			Irregular Heart Beat		
Cancer (Type)			Heart Failure / CHF		
Stroke			High Cholesterol		
Colitis / Irritable Bowel			Lung Disease		
Gout			Mental Disease		
Swollen / Painful Joints			MRSA / Serious Infection		
Diabetes			Wounds Not Healing Properly		
Gastro-esophageal Reflux			Sleep Apnea		
Thyroid Condition			Epilepsy / Seizures		
Osteoporosis			Neuropathy		

REVIEW OF SYSTEMS

**(Please circle any known medical problems –
if none, please "X" out entire section and initial)**

CONSTITUTIONAL - fever, unexplained weight loss, weight gain/obesity, night sweats, fatigue,

EYES – visual disturbance (glaucoma / macular degeneration)

CARDIOVASCULAR – angina, blood clots, pulmonary embolus, hypertension, anemia,
heart failure, coronary artery disease, fluid retention, arrhythmia,
shortness of breath, palpitations, syncope

RESPIRATORY – asthma, chronic obstructive pulmonary disease (COPD)

GASTROINTESTINAL – ulcers, liver disease, hepatitis

GENITOURINARY/NEPHROLOGY – pregnancy, urinary incontinence, renal failure

MUSCULOSKELETAL – osteoporosis, reflex sympathetic dystrophy, chronic pain syndrome,
fibromyalgia

DERMATOLOGIC – rash

PSYCHIATRIC – anxiety, depression, alcohol abuse, drug abuse

ENDOCRINE – diabetes (insulin/non-insulin dependent)

ALLERGY/IMMUNOLOGY – HIV/AIDS

Thank You !

Medicare laws and insurance companies require a complete medical history be obtained for all patients. The information submitted is subject to all privacy standards, regulations and procedures as outlined by HIPAA.