GREATER MICHIGAN ORTHOPEDICS

Medical History Form

Name:_____

Age:_____ **Today's Date:**_____

Date of Birth:_____ **Marital Status:**_____
SSN:_____
Occupation:_____
Primary Care Physician:_____
Where is your Problem? (Please circle)

Foot Ankle Knee Hip

Elbow Shoulder Back

Wrist Hand Other

Which Side? Right / Left / Both
Which hand is Dominant? Right / Left
Height: _____ **Weight:**_____
Problems (please check that apply)

- ☐ Pain? (0-10)_____
- ☐ Weakness?
- ☐ Instability/Giving way/Dislocation?
- ☐ Stiffness?
- ☐ Swelling?
- ☐ Other?

How did you injure yourself?

- ☐ No injury, just started hurting
- ☐ Sports (which sport?)_____
- ☐ Motor vehicle accident
- ☐ Work/Job

Is there a workers comp claim? Yes / No

Date of Injury?_____

How long have you had Symptoms?_____

Briefly describe your injury:_____
_____

Previous Treatments:

- ☐ Medications?_____
- ☐ Physical Therapy
- ☐ Injections
- ☐ Bracing
- ☐ Surgery?_____

Sports Level: None / Recreational / Competitive

Providers Initials: _____

Previous Surgeries: (include dates):_____
_____
_____
_____

Do you have pain at night? Yes / No
Does it waken you from sleep? Yes / No
Is the pain getting:
Better Worse Same

What makes the problem better? _____
_____
What makes the problem worse?_____
_____
Allergies: _____
Please list your medications: _____
_____
_____
_____
_____

Do you take blood thinners? Yes / No

Do any diseases run in your family? _____
_____

Medical History: (please check that apply)

- ☐ High blood pressure
- ☐ Heart attack
- ☐ Heart failure
- ☐ Peripheral Vascular disease
- ☐ Stroke
  - ☐ Residual defects?_____
- ☐ Dementia
- ☐ COPD
- ☐ Connective tissue disease
- ☐ Peptic Ulcer Disease/GERD
- ☐ Diabetes
  - ☐ Most recent HgbA1c?_____
  - ☐ Take Insulin
- ☐ Kidney Disease
  - ☐ Stage_____
- ☐ Cancer
  - ☐ If yes, please specify_____
- ☐ HIV
- ☐ Liver disease/Hepatitis
- ☐ Blood Clot
- ☐ Pulmonary Embolus
- ☐ Smoker
  - ☐ How Much?_____

Informed on smoking Risk?_____

Please continue on next page

Review of Systems:

1. **Constitutional/Genera** ☐ None ☐ Recent Weight change ☐ Chills ☐ Fever ☐ Weakness/Fatigue ☐ other _____
2. **Eyes** ☐ None ☐ Vision Change ☐ Glasses/contacts ☐ Cataracts ☐ Glaucoma ☐ other _____
3. **Ear, Nose, Throat** ☐ None ☐ Hearing Loss ☐ Ear Ache ☐ Ringing in ear ☐ other _____
4. **Cardiovascular** ☐ None ☐ Chest pain ☐ Swelling in legs ☐ Palpitations ☐ other _____
5. **Respiratory** ☐ None ☐ Shortness of Breath ☐ Wheezing, Asthma ☐ Frequent Cough ☐ other _____
6. **Gastrointestinal** ☐ None ☐ Acid Reflux ☐ Nausea or Vomiting ☐ Abdominal Pain ☐ other _____
7. **Musculoskeletal** ☐ None ☐ Muscle Aches ☐ Swelling of the Joints ☐ Stiffness in Joints ☐ other _____
8. **Skin** ☐ None ☐ Rash ☐ Ulcers ☐ Abnormal scars ☐ other _____
9. **Neurological** ☐ None ☐ Headaches ☐ Dizziness ☐ Numbness/tingling ☐ loss of sensation ☐ other _____
10. **Psychiatric** ☐ None ☐ Depression ☐ Nervousness ☐ Anxiety ☐ Mood Swings ☐ other _____
11. **Endocrine** ☐ None ☐ Excessive thirst or hunger ☐ Hot/Cold intolerance ☐ Hot flashes ☐ other _____
12. **Hematologic** ☐ None ☐ Easy Bruising ☐ Easy Bleeding ☐ Anemia ☐ other _____

What activities would you like to do if you were not injured or in pain?

_____

_____

Signature: _____ **Date:**_____

Name: _____

Providers Initials: _____