ORTHOPEDIC & SPORTS ENHANCEMENT CENTER

MEDICAL HISTORY

NAME (LAST, FIRST, MI):			TODAY'S DATE:
DATE OF BIRTH:	HEIGHT:	WEIGHT:	REFERRING MD:

HISTORY OF PRESENT COMPLAINT

REASON FOR VISIT:	DATE OF ONSET:
SEVERITY OF PAIN TODAY (1 = NO PAIN 10 = MOST SEVERE)	1 2 3 4 5 6 7 8 9 10
IS THERE ANYTHING THAT MAKES IT WORSE OR BETTER?	
HOW LONG DOES IT LAST?	
HAVE YOU HAD RECENT TESTING? (X-RAY, MRI, CT) IF YES, WHEN AND WHERE?	
ARE YOU CURRENTLY BEING TREATED FOR THIS ILLNESS/INJURY BY ANOTHER PHYSICIAN? IF YES, BY WHOM? WHAT TREATMENT HAS BEEN TRIED?	
IS THERE ANY POSSIBILITY THAT YOU MIGHT BE PREGNANT?	

PAST & PRESENT MEDICAL PROBLEMS:

_____

_____

_____

LIST ALL SURGERIES WITH APPROXIMATE DATES:

_____ _____

_____ _____

_____ _____

_____ _____

ALCOHOL USE ☐ NEVER ☐ OCCASIONAL ☐ OTHER _____

TOBACCO USE ☐ NEVER ☐ YES ☐ QUIT – WHEN? _____ PACKS PER DAY? _____

MAJOR FAMILY ILLNESS _____

_____

_____

_____

MEDICAL HISTORY (continued)

REVIEW OF SYSTEMS
(Circle any of the following that you are currently experiencing.)

CONSTITUTIONAL: Fever Chills Headache General Tiredness Weakness

INTEGUMENTARY: Skin Rashes Persistent Itching Other Skin Problems _____

EYES: Blurred Vision Double Vision Blind Spots Glaucoma Eye Pain

EARS/NOSE/THROAT: Any Chronic or Persistent Infections or Problems? _____

CARDIOVASCULAR: History of: Chest Pain/Angina High Blood Pressure Heart Murmurs

PULMONARY: History of: Persistent Cough Wheezing Shortness of Breath Pneumonia

GASTROINTESTINAL: Chronic: Nausea Vomiting Indigestion Heartburn Stomach Pain

MUSCULOSKELETAL: History of: Back Pain or Injury Neck Pain or Injury Joint Pain or Injury

NEUROLOGICAL: Tremor Dizzy Spells Numbness Tingling

ENDOCRINE: Excessive Thirst Weight Loss/Gain Feeling Too Hot/Too Cold

HEMATOLOGICAL: History of: Swollen Glands Excessive Bleeding Blood Clots

PSYCHOLOGICAL: Depression Anxiety Attacks Suicidal Thoughts