Dr. Mercer Medical History Questionnaire

ORTHOPEDIC SPECIALISTS, P.C.
PHYSICIANS & SURGEONS

Legal Name: _____ ❒ **Male** ❒ **Female**
Date of Birth: _____ **Age:** _____ **Primary Care Provider:** _____

Past Medical History: Please check the medical problems you have ❒ None

❒ Cancer
Type: _____
❒ Heart Disease ❒ Heart Attack
❒ High Blood Pressure
❒ Peripheral Vascular Disease
❒ Blood Clots ❒ PE
❒ Anemia
❒ Arrhythmia ❒ Atrial fibrillation
❒ Asthma
❒ Emphysema/COPD
❒ Sleep Apnea
❒ GERD (reflux)
❒ Ulcers
❒ Inflammatory Bowel Disease
❒ Kidney Disease
❒ Liver Disease ❒ Hepatitis C
❒ Diabetes : last HgbA1c _____
❒ Hypothyroid ❒ Hyperthyroid
❒ Prostate Problems
❒ Seizures
❒ Stroke ❒ TIA
❒ Dementia
❒ Rheumatoid Arthritis
❒ Psoriasis
❒ Osteoporosis
❒ Fibromyalgia
❒ Chronic Pain
❒ Depression ❒ Anxiety
❒ HIV
❒ Gout
❒ Other_____

Previous Surgeries:

_____

_____

Medications: ❒ None

list additional on back

Allergies: ❒ None

Medication	Reaction

❒ Metal Allergy

Social History:

Do you use tobacco? _____ How much? _____ppd Date you quit smoking: _____
Do you drink alcohol? _____ How much? _____/week Do you use recreational drugs? ❒ Yes ❒ No

❒ Married ❒ Single ❒ Widowed ❒ Significant other

Work Status: ❒ Working ❒ Paid leave ❒ Unpaid leave ❒ Unemployed
❒ Disabled ❒ Student ❒ Retired ❒ Occupation _____

Review of Systems: Check your **current/recent** symptoms ❒ None

❒ Fever ❒ Chills
❒ Weight Loss ❒ Gain
❒ Fatigue
❒ Excessive Sweating
❒ Rash
❒ Dry skin
❒ Headaches
❒ Numbness ❒ Tingling
❒ Weakness
❒ Incontinence
❒ Hair Loss
❒ Vision Changes
❒ Hearing Loss
❒ Nasal Congestion
❒ Dental Problems
❒ Sore Throat
❒ Allergies
❒ Shortness of Breath
❒ Cough
❒ Chest Pain
❒ Irregular Heartbeat
❒ Lightheadedness
❒ Leg Swelling
❒ Abdominal Pain
❒ Heartburn
❒ Nausea ❒ Vomiting
❒ Diarrhea
❒ Constipation
❒ Blood in Stool ❒ Urine
❒ Painful Urination
❒ Bleeding problems
❒ Stress

Family History: Check conditions in your immediate family ❒ None

❒ Heart Disease ❒ Cancer ❒ Bleeding Problems ❒ Foot deformity
❒ Diabetes ❒ Arthritis ❒ Stroke ❒ Anesthesia Difficulties

1st visit: Patient Signature:_____ Date:_____ Doctor Signature:_____

2nd visit: Patient Signature:_____ Date:_____ Doctor Signature:_____