Medical History Questionnaire

ORTHOPEDIC SPECIALISTS, P.C.
PHYSICIANS & SURGEONS

Legal Name: _____ ❒ **Male** ❒ **Female**
Date of Birth: _____ **Age:** _____ **Primary Care Provider:** _____
What are you being seen for today? _____

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

❒ Rash	❒ Enlarged Thyroid	❒ Shortness of Breath	❒ Loss of Bowel Control
❒ Psoriasis	❒ Excessive Thirst/Appetite	❒ Wheezing	❒ Weight Loss/Gain
❒ Easy Bruising	❒ Sore Throat	❒ Headache/Migraine	❒ Joint Swelling
❒ Glasses or Contacts	❒ Hoarseness	❒ Convulsions/Seizures	❒ Blood in Urine/Stool
❒ Hearing Loss	❒ Snoring	❒ Numbness	❒ Painful Urination
❒ Ringing in Ears	❒ Irregular Heart Beat	❒ Mood Changes	❒ Loss of Bladder Control
❒ Sinus Problems	❒ Heart Murmur	❒ Nausea/Vomiting	❒ Cough/Sputum Production
❒ Breathing Problems	❒ Chest Pain	❒ Fever/Chills	❒ Bleeding Problems

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

❒ Pace Maker	❒ Congestive Heart Failure	❒ Tuberculosis	❒Blood Clots
❒ Ulcers	❒ Arthritis	❒ Seizures	❒ Prostate Problems
❒ Cancer	❒ HIV	❒ Kidney/Bladder Infection	❒ Asthma
Type: _____	❒ Liver Disease/Hepatitis	❒ Stroke	❒ Emphysema/COPD
❒ Diabetes	❒ Heart Disease/Attack	❒ High Blood Pressure	❒ Osteoporosis
Type: _____	❒ Depression/Psychiatric	❒ Kidney Disease/Failure	❒ Gout

Previous Surgeries:

_____

_____

Have you ever had a reaction to anesthesia? ❒ Yes ❒ No

Family History: Check conditions in your immediate family

❒ Hypertension	❒ Heart Disease	❒ Cancer	❒ Bleeding Problems
❒ Diabetes	❒ Arthritis	❒ Stroke	❒ Anesthesia Difficulties

Medications: ❒ None

Medicines	Dose	How Often
		list additional on back

Allergies: ❒ None

Medication	Reaction	Medication	Reaction

Social History:

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

❒ Married	❒ Single	❒ Widowed	❒ Significant other
Work Status: ❒ Working	❒ Paid leave	❒ Unpaid leave	❒ Unemployed
❒ Disabled ❒ Student	❒ Retired	❒ Occupation _____	

Patient Signature:_____ Doctor Signature:_____ Date:_____

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