PERSONAL MEDICAL HISTORY

NORTHWEST OKLAHOMA ORTHOPAEDIC CLINIC

A complete medical record is the best way to assure your physician is well informed about your medical conditions.
Please complete this form in a legible and purposeful manner

PATIENT INFORMATION

Name: BIrthdate: Age: Visit Date:

Primary care physician/provider: Who referred you?

What is your dominant hand:: ☐ Left ☐ Right **Height** _____ **Weight** _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated Gender: ☐ Male ☐ Female

The **first** best number to reach you ( ) _____ - _____ ☐ Cell ☐ Home ☐ Work ☐ Other

The **second** best number to reach you ( ) _____ - _____ ☐ Cell ☐ Home ☐ Work ☐ Other

Current Email address:

VISIT HISTORY *(More than one reason for visit must be approved by our office prior to your appointment for scheduling purposes)*

Reason for visit? | Is this work related? ☐ Yes ☐ No

How did the problem start or injury occur?_____

_____

_____

Date of Onset / Accident
Or how many days, weeks, months or years:

_____

Describe the expectations of today's visit:_____

ALLERGIES

Any **LATEX** allergy? ☐ Yes ☐ No If YES, are special precautions taken ☐ Yes ☐ No
Any **METAL** allergy? ☐ Yes ☐ No Include difficulties with wearing metal jewelry against skin

List medical allergies and the reactions with each *(Note if they are Mild, Moderate, or Severe):*

_____ _____
_____ _____
_____ _____

MEDICATIONS

List the prescription medications taken on a regular basis with **their doses and frequency** and then list any over-the-counter and herbal medications. (If a list is attached, the doses and frequencies must be present on the list)

_____ _____ _____
_____ _____ _____
_____ _____ _____

On any blood thinners? ☐ Yes ☐ No (e.g. Aspirin/Plavix/Coumadin/NSAIDs/Xarelto/Pradaxa/Eliquis/Cayenne Pepper/Garlic/Other)

Name and city of preferred pharmacy:

PAST SURGICAL HISTORY

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

Turn Over Page ....

PAST MEDICAL HISTORY

(check all that apply)

- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Back/Neck Surgery
- ☐ Bleeding Disorder
- ☐ Blood Clots
- ☐ Cancer _____
- ☐ Cardiac Arrhythmias
- ☐ Chronic Pain Syndrome
- ☐ Congestive Heart Failure
- ☐ Diabetes, Type I
- ☐ Diabetes, Type II
- ☐ Fibromyalgia
- ☐ Fracture _____
- ☐ GERD / Reflux
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Attack / MI
- ☐ Heart Disease _____
- ☐ Hepatitis - Type _____
- ☐ High Blood Pressure
- ☐ HIV / AIDS
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Lupus
- ☐ Mental Illness
- ☐ Malignant Hyperthermia
- ☐ Migraines
- ☐ Multiple Sclerosis
- ☐ Muscle Disease
- ☐ Neuropathy
- ☐ Organ Transplant
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson's Syndrome
- ☐ Prostate Disease
- ☐ Psoriasis
- ☐ Rheumatoid Arthritis
- ☐ Scleroderma
- ☐ Spinal Stenosis
- ☐ Stomach Ulcers
- ☐ Stroke / TIA
- ☐ Seizure Disorder
- ☐ Sickle-Cell
- ☐ Sleep Apnea
- ☐ Substance Abuse/Addiction
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Vascular Disease
- ☐ Other:

Any history of **blood clots (DVT or PE) to the LUNG or LEGS**? ☐ Yes ☐ No If so, what treatment? _____

If **diabetic**, what was last HgA1c? _____ ☐ Unknown or not sure

For **female** patients - has there been ☐ Hysterectomy ☐ Bilateral tubal ligation ☐ Postmenopausal

Are there any **metal implants** in your body? ☐ Yes ☐ No If so, where: _____

FAMILY HISTORY

☐ Heart disease ☐ Diabetes ☐ Stroke / CVA ☐ Cancer _____ ☐ Reaction to anesthesia ☐ Other

List any other family health information or illness that run in your biological family: _____

_____

SOCIAL HISTORY

Smoke or use tobacco?	☐ Never ☐ Occasionally ☐ Daily ☐ Quit; When _____ Type of tobacco _____
Use of E-cigarettes?	☐ Never ☐ Occasionally ☐ Daily ☐ Quit; When _____
Drink alcohol?	☐ Never ☐ Moderate / Socially ☐ Daily
Recreational or illicit drugs?	☐ Never ☐ Occasionally ☐ Daily ☐ Quit; When _____

Living status	☐ Independent ☐ Alone ☐ Nursing home ☐ Assisted Living ☐ Other _____
Assistive Devices	☐ None ☐ Crutches ☐ Cane ☐ Walker ☐ Wheelchair ☐ Prosthesis
Can you?	☐ Drive ☐ Shop ☐ Cook ☐ Manage your own finances

If you have a **Medical Power of Attorney**, put their name here: _____

REVIEW OF SYSTEMS

General	☐ Unplanned weight loss ☐ Fever ☐ Fatigue ☐ Chills ☐ Nausea
Eyes	☐ Pain ☐ Poor vision ☐ Corrective lenses
Ear/Nose/Throat	☐ Sore throat ☐ Hoarseness ☐ Ears ringing ☐ Nose bleeds ☐ Vertigo
Respiratory	☐ Wheezing ☐ Coughing ☐ Shortness of breath ☐ Sleep apnea
Cardiovascular	☐ Chest pain ☐ Fainting ☐ Feet / legs swelling ☐ Palpitations ☐ Irregular heartbeat
Gastrointestinal	☐ Abdominal pain ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Bowel problems / changes
Urinary	☐ Pain / burning urination ☐ Frequency ☐ Flank pain ☐ Voiding difficulty ☐ Urgency
Musculoskeletal	☐ Joint swelling ☐ Joint redness ☐ Joint pain ☐ Gait problems
Skin	☐ Rash ☐ Itch ☐ Sores ☐ Abscess ☐ Discharge
Endocrine	☐ Excess sweat ☐ Excess thirst ☐ Heat intolerance ☐ Cold intolerance
Heme/Lymph	☐ Bleeding or clotting problems ☐ Bruising easily ☐ Lymph node swelling
Psych	☐ Anxiety ☐ Depression ☐ Severe stress ☐ Panic attacks ☐ Claustrophobia

SIGNATURE _____ Date _____ Rev. 04/04/2018