THE ORTHOPEDIC AND SPORTS MEDICINE CENTER OF OREGON

MEDICAL HISTORY Date:

PLEASE PRINT ALL INFORMATION						
NAME:				**DOB:**		
What is your approximate weight? Lbs.			Height? ft in			
Referred here by: (circle one) self	family	friend	doctor	attorney	other	
Name of Person / Physician making referral:						
List Current Treating Physicians including PCP:						
Describe the reason for your visit:						
Body Part to be examined:			Right	Left	Both	
How did your symptoms/injury begin? (describe in detail)						
Approximate date symptoms began or date of injury:			New or Old injury (circle one)			
On a scale of 1-10 (10 being most severe) circle the # that best describes your pain:	1	2	3	4	5	6 7 8 9 10
Resulting from: (circle which applies) Sports	Accident	Work Related	Involving Litigation			
Are Symptoms: constant	intermittent	worsening	improving	unchanged		
Circle all that apply: pain	stiffness	swelling	instability	weakness	numbness/tingling	
What makes symptoms worse?						
What makes symptoms better?						
What previous formal treatment have you had for this problem? (Medications, therapy, surgery, injections)						

PAST SURGICAL HISTORY

Previous Type of Operation	Year
1.	
2.	
3.	
4.	
5.	

Any previous fractures? YES ☐ NO ☐ WHERE?

****DO YOU HAVE ANY DRUG ALLERGIES? ** (circle one) YES NO**

If yes, name the drug and describe the reaction, please be specific. (Example: rash, nausea, etc)

CURRENT MEDS: (List any medications you are taking at this time. Include items such as aspirin, vitamins, etc.

NAME OF DRUG	REASON FOR USE	DOSING INSTRUCTIONS (strength & frequency)	Start Date
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

PLEASE TURN OVER AND COMPLETE MEDICAL HISTORY

MEDICAL HISTORY/ REVIEW OF SYSTEMS

Please check if you have a history of any of the following	YES	NO		YES	NO
GENERAL			**CARDIOVASCULAR**		
Are you currently pregnant?			Chest Pain/Angina		
Diabetes – type I ☐ type II ☐			Heart Attack/Myocardial Infarction		
Stroke			Palpitations		
Kidney Disease			High Blood Pressure / Hypertension		
Ulcers			Shortness of Breath		
Asthma or Lung Disease			Swelling of Lower Extremities		
Cancer: Type?			**HEMATOLOGIC**		
Fatigue			Anemia		
Weakness			Blood Clots		
Fevers			Bleeding Tendency		
Skin problems/disorders: Type?			Easily Bruised		
Rheumatic Fever			Circulatory Problems		
Tuberculosis			Currently on Blood Thinners		
Recent weight gain/loss: (circle one) How much?			--if yes, what type?		
BLOODBORNE PATHOGENS			Phlebitis		
HIV / AIDS			**MUSCULOSKELETAL**		
Hepatitis			Joint Pain		
Other			Joint Swelling		
SITES OF INFECTION			Muscle Weakness		
Urinary			Muscle Tenderness		
Dental			Morning Stiffness		
Other			Arthritis / Osteoarthritis		
NEUROLOGICAL			Rheumatoid Arthritis		
Headaches			Osteoporosis		
Dizziness			Bone / Joint Infections		
Fainting			Gout		
Memory Loss			**PSYCHOLOGICAL**		
Loss of Consciousness			Depression		
Muscle Spasms			Anxiety Disorder		
Numbness or Tingling of Hands/Feet			**Other illnesses or diseases which are not listed?**		
Blindness or Trouble Seeing					
Deafness or Trouble Hearing					
Seizures					

FAMILY HISTORY

Please check if any of your family (parents, brothers, sisters, grandparents) have a history of any of the following:

	YES	NO		YES	NO
Diabetes (sugar)			Abnormal Bleeding Tendencies		
Heart Disease			Rheumatoid Arthritis		
Anesthetic Complications			Osteoarthritis		
Cancer: Type?			Gout		

SOCIAL HISTORY

Occupation: Job Duties:

Marital Status: # of Children ____

Do you smoke? YES ☐ If Yes: How many packs per day?___ Year Started____ Have you been counseled to quit or cut down? YES ☐ NO ☐
NO ☐ If No: Former Smoker? YES ☐ Year Started____ Year Quit____

Do you consume alcohol? YES ☐ NO ☐ If so, how many drinks per week? _____ Is there a history of abuse? YES ☐ NO ☐

Have you ever had a problem with drugs? YES ☐ NO ☐

Do you participate in recreational drug use? YES ☐ NO ☐ If yes, or in past, list type and amount:

Please list all sports and hobbies you are involved in:

Patient Signature: I, as the patient, state the information is correct and accurate to the best of my knowledge.	**Physician Signature:**