THE ORTHOPEDIC AND SPORTS MEDICINE CENTER OF OREGON

MEDICAL HISTORY

NAME:_____DOB: _____

HEIGHT:_____ft. _____in. WEIGHT: _____lbs. GENDER: ☐ MALE ☐ FEMALE

PRIMARY CARE PHYSICIAN:_____PHARMACY: _____

OCCUPATION: _____MARITAL STATUS:_____# CHILDREN_____

THIS INFORMATION IS VITAL IN THE AUTHORIZATION AND CLEARANCE PROCESS FOR ANY IMAGING, DIAGNOSTIC AND/OR SURGICAL PLANNING

DESCRIBE THE REASON FOR VISIT: _____

WHEN DID THIS EPISODE OF SYMPTOMS BEGIN?_____

SCALE OF 1-10 (10 is most severe) circle the # that best describes your pain: 1 2 3 4 5 6 7 8 9 10

CIRCLE ALL THAT APPLY: pain stiffness swelling instability weakness locking numbness

ARE SYMPTOMS: constant intermittent worsening improving unchanged

RESULTING FROM: sports accident work related injury motor vehicle accident

WHAT MAKES SYMPTOMS WORSE? _____

WHAT MAKES SYMPTOMS BETTER? _____

HAND DOMINANCE (circle one): LEFT RIGHT

List any treatments that you have had for this problem below or check NONE: ☐ NONE

MEDICATIONS: _____DATE STARTED:_____

THERAPY: _____DATE STARTED:_____

INJECTIONS: _____DATE STARTED:_____

IMAGING: (MRI/CT/XRAY) LOCATION:_____WHEN:_____

ALLERGIES (INCLUDING REACTION) TO MEDICATIONS, X-RAY DYES OR OTHER SUBSTANCES ☐ NONE

_____

_____

_____

DO YOU HAVE OR USE ANY OF THE FOLLOWING: ☐ NONE

☐ Implants	☐ Pacemaker	☐ CPAP
☐ Stent / Shunt	☐ Nerve Stimulator	☐ Loose or removable teeth

REVIEW OF SYSTEMS **Please check if you have history of any of the following:** ☐ NONE

GENERAL		***CARDIOVASCULAR***		***HEMATOLOGIC***	
Pregnant or Nursing		Chest Pain / Angina		Anemia	
Diabetes I or II ? A1C? _____		Heart Attack		Blood Clots	
MRSA		Myocardial Infarction		Bleeding Tendency	
Kidney Disease		Palpitations		Easily Bruised	
Stomach or intestinal problems		High Blood Pressure		Circulatory Problems	
Asthma or Lung Disease		Shortness of breath		Currently on Blood Thinners	
Cancer Type? _____		Swelling of lower extremities		Type?	
Fatigue		Sleep Apnea		Phlebitis	
Weakness		**NEUROLOGICAL**		***MUSCULOSKELETAL***	
Fevers		Headaches		Joint pain	
Skin disorders: Type?_____		Dizziness/Fainting		Joint swelling	
Rheumatic Fever		Stroke		Muscle weakness	
Tuberculosis		Memory Loss		Muscle tenderness	
Recent weight gain/loss		Muscle Spasms		Morning stiffness	
Recent cold or flu		Numbness/Tingling of hands or feet		Arthritis / Osteoarthritis	
Depression		Blindness or Trouble Seeing		Where? _____	
Anxiety		Deafness or Trouble Hearing		Rheumatoid Arthritis	
INFECTION		Seizures		Osteoporosis	
Dental		***BLOODBORN PATHOGENS***		Gout	
Urinary		HIV / AIDS		Bone or joint infections	
Other:		Hepatitis		Fractures	

FAMILY HISTORY

Please check the following if any family member has a history of the condition listed: ☐ NONE

- ☐ DIABETES
- ☐ HEART DISEASE
- ☐ ANESTHETIC COMPLICATIONS
- ☐ BLEEDING DISORDER
- ☐ RHEUMATOID ARTHRITIS
- ☐ GOUT
- ☐ OSTEOARTHRITIS
- ☐ REACTION TO ANESTHESIA
- ☐ BLOOD CLOTS
- ☐ CANCER TYPE(S): _____

Have you or a family member had a bad reaction to anesthesia? ☐ Yes ☐ No

HAVE YOU HAD ANY PREVIOUS FRACTURES? ☐ Yes ☐ No

Which body part(s):

_____

PAST SURGICAL HISTORY ☐ NONE

TYPE OF OPERATION:	YEAR:

CURRENT MEDICATIONS, SUPPLEMENTS AND OVER-THE-COUNTER MEDICATIONS ☐ NONE

MEDICATION	REASON	FREQUENCY

Current tobacco smoker? YES NO

Packs per day _____

Smokeless tobacco? YES NO

Former tobacco smoker? YES NO

Year quit? _____

Never smoker? YES NO

Do you consume alcohol? YES NO

History of abuse? YES NO

Drinks per week: _____

Recreational drug use? YES NO

Type: _____

Frequency:_____

List sports and hobbies are you involved in:

_____

_____

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