

**Great Plains Orthopaedics
Medical History/Problem Form**

Name: _____ Date _____ Height _____ Current Weight _____
 DATE OF BIRTH _____ Dominant Hand _____ Marital Status _____
 Occupation: _____ Family Doctor: _____
 Was an injury involved: Yes No Date of Injury: _____ Other treating doctors: _____
 Is your injury work related? Yes No How: _____

Briefly state the reason for today's visit: _____

Have you had any of the following pertaining to this problem? (Please circle) If so, give location and date:

X-rays _____ Bone Scan _____ MRI _____ Nerve Tests _____

Present or Past Medical History (Check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Stroke | <input type="checkbox"/> HIV/Aids |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Do you bring anything up when you cough? |
| <input type="checkbox"/> Heart Murmur/Rheumatic Fever | <input type="checkbox"/> Seizures | <input type="checkbox"/> Asthma/Emphysema |
| <input type="checkbox"/> Do you take antibiotics before dental work? | <input type="checkbox"/> Cancer Where? _____ | <input type="checkbox"/> Sleep apnea <input type="checkbox"/> Use of Cpap |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Skin Problems: rash, sores | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Irregular Pulse | <input type="checkbox"/> Stomach/intestinal disease/Hiatal Hernia/Acid Reflux | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Hepatitis/Jaundice |
| <input type="checkbox"/> Coronary Artery Disease/Angiogram | <input type="checkbox"/> Jaw or neck fracture/surgery | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Kidney Problems/Failure | <input type="checkbox"/> Blood Clot/Bleeding Disorder |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Difficulty urinating | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Alcohol/Drug Abuse | | <input type="checkbox"/> Other |

Surgeries (check all that apply)	DATE	PLEASE LIST ALL SURGERIES DONE	DATE
Appendectomy <input type="checkbox"/>			
Tonsillectomy <input type="checkbox"/>			
Gallbladder <input type="checkbox"/>			
Hysterectomy <input type="checkbox"/>			
Cataracts <input type="checkbox"/>			
Hernia R <input type="checkbox"/> L <input type="checkbox"/>			

Describe any problems with anesthesia/Novocaine in past: _____

Hearing: Normal Hearing Aids Impaired
 Vision: Normal Glasses Contacts Glaucoma
 Dentures: None Upper Lower
 Partial: None Upper Lower
 Date of Last Period: _____

Alcohol intake: No Yes-amount _____
 Do you now, or have you ever used: Cigarettes Packs/Day ___x___ years
 Chewing tobacco X ___ years Cocaine X ___ years
 Marijuana X ___ years Never Smoked
 Quit Smoking - Date _____

Allergies/Reactions (Check all that apply)

<input type="checkbox"/> None Known	<input type="checkbox"/> Penicillin _____	<input type="checkbox"/> Codeine _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Latex _____	<input type="checkbox"/> Erythromycin _____	<input type="checkbox"/> Sulfa _____	
<input type="checkbox"/> Tape _____	<input type="checkbox"/> Exam Dyes _____		

Family History Has any blood relative ever had: (Check all that apply)

<input type="checkbox"/> Alzheimer's disease	<input type="checkbox"/> Cancer; type _____	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Memory loss	<input type="checkbox"/> Other _____
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Osteoporosis	
<input type="checkbox"/> Bleeding problem	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Stroke	
			<input type="checkbox"/> Tuberculosis	

CURRENT MEDICATIONS – Also include any over-the-counter medications such as vitamins, antihistamines, Tylenol, herbal remedies, etc.

Drug	mg	Time of day taken	Drug	mg	Time of Day Taken

The above information is complete and correct.

Patient Signature _____ Date _____

Revised 5/10/07

M.D. Signature _____ Date _____

Word/Favorites/Form.med hx

Information reviewed (initials & date) _____

Procedure & date _____