

ORTHOPEDIC CLINIC *of Appleton, Inc.*

Medical History

Name: _____ Today's Date: _____

Height: _____ Weight: _____ Date of Birth: _____

Chief Complaint

Why are you seeing the doctor today? _____

Current problem is the result of a(n): Check all that apply

Car Accident Work Accident Accident Date of Injury _____
 Other _____

This occurred during: Check all that apply

Lifting Pulling Pushing Twisting Falling Bending
 Reaching Squatting Hit by Object Not known

Medications taken in last 30 days:

Medication	Dose	How Long?	Side Effects

ALLERGIES: (Including drug allergies)

Review of Systems

Are you currently having or have you had problems with your: (within last six months)

- | | | |
|---------------------------------------|-----------------------------------|---|
| _____ Headache | _____ Fear of being seriously ill | _____ Chest pain |
| _____ Dizziness | _____ Difficulty swallowing | _____ Palpations of the heart |
| _____ Vertigo | _____ Bowel disturbance | _____ Coughing up blood |
| _____ Fainting spells | _____ Diarrhea | _____ Vein problems or clots in the legs or lungs |
| _____ Visual disturbance | _____ Constipation | _____ Swelling in the ankles |
| _____ Hearing loss or disorder | _____ Blood in stool | _____ Numbness in the hands |
| _____ Infections of the gums or teeth | _____ Nausea | _____ Numbness in the feet |
| _____ Anxiety | _____ Heartburn | _____ Gain of more than 10 pounds |
| _____ Depression | _____ Excessive gas or belching | _____ Loss of more than 10 pounds |
| _____ Insomnia (difficulty sleeping) | _____ Abdominal bloating | _____ Thyroid disease or goiter |
| _____ Chronic fatigue or tiredness | _____ Urinary disturbance | _____ Back pain |
| _____ Generalized weakness | _____ Difficulty urinating | _____ Frequent joint pains or swelling |
| _____ Loss of appetite | _____ Burning on urination | _____ Frequent muscular aches or soreness |
| _____ Crying spells | _____ Blood in the urine | _____ Skin disorders |
| _____ Confusion | _____ Shortness of breath | _____ Other: _____ |
| _____ Feeling of uncertainty | _____ Wheezing | _____ |
| | | _____ |

