UNIVERSITY HIP & KNEE
ORTHOPAEDIC SPECIALISTS LLC

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MEDICAL HISTORY FORM

Today's Date: ____/____/____

Patient Name:_____ **DOB:** ____/____/____

Body Part Symptomatic: _____ **Side of Body: Right Left Bilateral**

Current Symptoms: Pain Swelling Stiffness Numbness Weakness Mass/lump Black/Blue
How long have you had these symptoms? _____

Please rate the severity of your symptoms: (1 minimal/ 10 severe) 1 2 3 4 5 6 7 8 9 10

Review of Systems/Medical History

Cardiovascular:

1. Irregular Heartbeat/palpations No Yes, explain:_____
2. Heart Attack No Yes, explain:_____
3. Heart Disease No Yes, explain:_____
4. High Cholesterol No Yes, explain:_____
5. High Blood Pressure No Yes, explain:_____
6. Stroke No Yes, explain:_____
7. Leg Swelling (L R Both) No Yes, explain:_____

Respiratory:

1. Asthma No Yes, explain:_____
2. COPD/Emphysema No Yes, explain:_____
3. Shortness of Breath/Wheezing No Yes, explain:_____

Hematologic/Oncology:

1. Cancer No Yes, explain:_____
2. Bleeding/Bruising No Yes, explain:_____
3. Blood Clot/DVT No Yes, explain:_____

Skeletal:

1. Osteoarthritis No Yes, explain:_____
2. Rheumatoid Arthritis No Yes, explain:_____

Integumentary:

1. Skin Disease No Yes, explain:_____
2. Open Wounds/Ulcers No Yes, explain:_____

Endocrine:

1. Thyroid No Yes, explain:_____
2. Diabetes No Yes, explain:_____

Renal:

1. Kidney No Yes, explain:_____
2. Prostate/BPH No Yes, explain:_____

Nervous:

1. Seizures No Yes, explain:_____
2. Parkinson's Disease No Yes, explain:_____

Digestive:

1. Irritable Bowel (IBS) No Yes, explain:_____
2. GERD (Reflux) No Yes, explain:_____

Muscular:

1. Weakness No Yes, explain:_____

Psychiatric:

1. Depression No Yes, explain:_____
2. Anxiety No Yes, explain:_____

Have you had a Dexa (Bone Density) Scan? No Yes **When?**_____

Reviewed by: _____ Date: ____/____/____

Social History

Age:_____ **Height:**_____ **Weight:** _____

Occupation/Retired:_____

Do you drink alcohol: No Socially Weekly Daily
Do You Smoke? No Yes ____ Packs/Day For ___ years **Previous Smoker?** _____ **Duration:**_____
Marital Status: __Married __ Single __ Divorced __ Widowed
Living Conditions: __Alone __Spouse __Family Member __Assisted Living **House Style**: ___Ranch ___Multi-story/Stairs

Activities: Swimming Weights Aerobics Golf Tennis Other:_____

Family History

Have any of your family members had problems with:

Arthritis	No	Yes, explain:_____
Cancer	No	Yes, explain:_____
Diabetes	No	Yes, explain:_____
High Blood Pressure	No	Yes, explain:_____
Heart Disease	No	Yes, explain:_____
Other	No	Yes, explain:_____

Surgical Procedures: _____

Orthopaedic Procedures: _____

Are you currently taking any Medications? ____NO _____YES, please List:_____

ALLERGIES:

Do you have any drug allergies? _____NO _____YES, List & Reaction _____

PREFERRED PHARMACY

Name:_____ Address:_____

Phone Number:_____

MEDICAL DOCTOR:

Who is your

Primary Medical Doctor? _____ Phone Number: _____

Cardiologist? _____ Phone Number: _____

Pulmonologist? _____ Phone Number: _____

Patient's Signature

Date