

THE ORTHOPEDIC AND SPORTS MEDICINE CENTER OF OREGON

MEDICAL HISTORY

PLEASE PRINT ALL INFORMATION		DATE:	
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? <input type="checkbox"/> YES <input type="checkbox"/> NO WHERE?			
DRUG ALLERGIES: 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	Dose (strength and number of pills per day)	NAME OF DRUG	Dose (strength and number of pills per day)
1.		9.	
2.		10.	
3.		11.	
4.		12.	
5.		13.	
6.		14.	
7.		15.	
8.		16.	

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			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					
Urinary			Muscle Weakness		
Dental			Muscle Tenderness		
Other			Morning Stiffness		
NEUROLOGICAL			Arthritis / Osteoarthritis		
Headaches			Rheumatoid Arthritis		
Dizziness			Osteoporosis		
Fainting			Bone / Joint Infections		
Memory Loss			Gout		
Loss of Consciousness			PSYCHOLOGICAL		
Muscle Spasms			Depression		
Numbness or Tingling of Hands/Feet			Anxiety Disorder		
Blindness or Trouble Seeing			Other		
Deafness or Trouble Hearing					
Seizures					

Other illnesses or diseases which are not listed? Please describe:

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		

SCOCIAL HISTORY

Occupation: _____ Job Duties: _____
 Marital Status: _____ Children: _____ # _____
 Do you currently smoke? YES NO If yes or in past, # packs per day? _____ # of years _____
 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: _____ **Physician Signature:** _____