ROME ORTHOPAEDIC CENTER – PATIENT MEDICAL HISTORY FORM – PLEASE COMPLETE BOTH SIDES

Patient Name: _____ **Today's Date**: ____/____/____ **Race:**_____ **Ethnicity:** _____

Date of Birth: _____/_____/_____ **Age:** _____ **Height**: _____**Weight**: _____ **Preferred Language:** _____ **R or L Handed (circle one)**

Primary Care Physician: _____ **Who Referred You to Us**? _____

Reason for Today's Visit: _____

Are You Experiencing: (circle) Constant Pain Pain that Comes and Goes Numbness Weakness Swelling Stiffness Night Pain

Is your pain: (circle) Sharp Dull Stabbing Throbbing Aching Burning Radiating **Does this pain wake you from sleep**: Yes No

Since your problem started, is it: Getting Better Getting Worse Staying the Same

Do you have (circle any): Bruising / Tingling / Giving Way / Locking or Catching / Loss of Bowel or Bladder Control / Radiating Pain

On a scale of 1-10 (10 being worst) how severe is your pain: _____ at best _____at worst

What makes your symptoms worse: Standing Walking Lifting Exercise Twisting Lying Down Bending Squatting Kneeling Stairs Sitting Coughing/Sneezing Movement

What makes your symptoms better: Rest Elevation Ice Heat Other: _____

What medications or treatments have you had for this problem: _____

Have any of the following tests/procedures related to this problem been done: Physical Therapy

Cortisone Injection Pain Management

Is this due to an injury? Yes No **If yes, date of injury**: _____/_____/_____ **Is this Sports/Recreation related?**: Yes No

Is this a Work Injury? Yes No **Is there a W/C Claim?**: Yes No **Is this an Automobile Accident?**: Yes No

Other/Description of Injury: _____

If no injury, was the onset? Gradual Sudden **Duration of Problem**: _____ **Ever had a similar problem before?**: Yes No

If you are a current high school or college athlete: **School Name**: _____**Trainer Name**: _____

What sport do you play? _____**Position:** _____

MEDICAL HISTORY (Circle Yes or No for current and previous illnesses)

Asthma	Yes	No	Diabetes (If yes, ____Type I or ____Type II)	Yes	No
High Blood Pressure	Yes	No	History of Ulcers	Yes	No
Stroke	Yes	No	Cancer	Yes	No
Seizure/Convulsions	Yes	No	Rheumatologic Disease	Yes	No
Bleeding Disorder	Yes	No	HIV / AIDS	Yes	No
Thyroid Disorder	Yes	No	Hepatitis (If yes, Type _____)	Yes	No
Depression/Anxiety	Yes	No	Blood Clots	Yes	No
Scoliosis	Yes	No	Staph Infection	Yes	No
Are You Pregnant?	Yes	No	Heart Attack or Heart Failure:	Yes	No
Stents	Yes	No	Pacemaker	Yes	No

Other: _____

SURGICAL HISTORY (List procedure, approximate date and surgeon)

____ None _____ _____

_____ _____

CURRENT MEDICATIONS (include dose and frequency if known)

____ None _____ Birth Control Pills _____

_____

_____ Complete Other Side

Page Two Patient Name: _____ Preferred Pharmacy and Location: _____

DRUG ALLERGIES AND REACTIONS

____None ____ Latex _____ _____ _____

Family History (Circle any illnesses that parents, siblings, or children have had and list relationship)

Hypertension:_____ Heart Disease:_____Seizures:_____Stroke:_____ Diabetes:_____ Cancer:_____Osteoarthritis: _____

Social History

Marital Status: _____Single _____Married _____Widowed _____Divorced Number of People Living In Home: _____

Alcohol Use: _____Never _____Rarely _____Moderate _____Daily Illegal Drug Use / Type: _____

Tobacco Use: _____Never _____Currently _____Previously, But Quit _____ # Packs Per Day _____ # Years

Occupation: _____ Employer: _____

Review of Systems: (circle Yes or No)

Constitutional Symptoms			**Skin**			
	Good General Health	Yes	No		Rash or Itching	Yes	No
	Recent Weight Change	Yes	No		Psoriasis	Yes	No
	Fever	Yes	No	**Genitourinary**			
	Fatigue	Yes	No		Frequent Urination	Yes	No
	Headaches	Yes	No		Painful Urination	Yes	No
Eyes					Blood in Urine	Yes	No
	Wear Glasses	Yes	No		Kidney Stones	Yes	No
	Wear Contacts	Yes	No	**Gastrointestinal**			
	Blurred/Double Vision	Yes	No		Loss of Appetite	Yes	No
	Glaucoma	Yes	No		Nausea / Vomiting	Yes	No
Ears / Nose / Throat / Mouth					Frequent Diarrhea	Yes	No
	Hearing Loss	Yes	No		Heartburn	Yes	No
	Ringing in Ears	Yes	No		Abdominal Pain	Yes	No
	Sinus Problems	Yes	No	**Neurological**			
	Sore Throat	Yes	No		Lightheaded / Dizzy	Yes	No
	Voice Change	Yes	No		Tremors	Yes	No
Cardiovascular					Paralysis	Yes	No
	Chest Pain	Yes	No	**Psychiatric**			
	Palpitations	Yes	No		Depression	Yes	No
	Swelling of Feet / Hands	Yes	No		Memory Loss	Yes	No
	High Blood Pressure	Yes	No		Insomnia	Yes	No
Pulmonary					Nervousness	Yes	No
	Chronic Cough	Yes	No	**Hematologic / Lymphatic**			
	Shortness of Breath	Yes	No		Anemia	Yes	No
	Sleep Apnea	Yes	No		Deep Vein Thrombosis	Yes	No
	Blood Clots	Yes	No		Phlebitis	Yes	No
Musculoskeletal					Past Blood Transfusion	Yes	No
	Osteoporosis	Yes	No	**Endocrine**			
	History of Fractures	Yes	No		Heat / Cold Intolerance	Yes	No
	Rheumatoid Disease	Yes	No				
	Gout	Yes	No				

Patient or Guardian Signature _____ Date of Completion: _____/_____/_____

Reviewed By: _____ Date Reviewed: _____/_____/_____