advocare | Orthopedic Reconstruction Specialists

Medical History

Date: _____ Name: _____ Age: _____ ☐ Male ☐ Female

DOB: _____ Height: _____ Weight: _____ ☐ Right Handed ☐ Left Handed

Employed: ☐ Yes ☐ No Occupation: _____

Are you currently working? ☐ Yes ☐ No

Family Physician: _____ Who referred you? _____

Describe the problem and symptoms you are seeing the doctor for today:

_____

_____

Injured Side (if applicable): ☐ Right ☐ Left Date of Injury: _____

When did the problem begin? _____ Is this work related? ☐ Yes ☐ No

Have any tests been done?	Location	Date
X-Rays		
CT Scan		
MRI		
EMG		
Other		

Have any treatments been done for this problem? _____

LIST ALL ALLERGIES: _____

List all past surgery with dates if known:

_____

_____

Have you ever had, or do you presently suffer from:

	Yes	No		Yes	No
1. Seizures / Stroke	☐	☐	14. Ulcer / Stomach Bleed / Indigestion	☐	☐
2. Angina, heart failure or attack	☐	☐	15. Thyroid disorder	☐	☐
3. Irregular heartbeat	☐	☐	16. Depression / Anxiety	☐	☐
4. High blood pressure	☐	☐	17. Chemical dependency / Alcoholism	☐	☐
5. Asthma / Shortness of Breath	☐	☐	18. Blood clots / Phlebitis	☐	☐
6. Emphysema / Chronic Bronchitis	☐	☐	19. Bleeding disorder	☐	☐
7. Hearing loss	☐	☐	20. Difficulty voiding	☐	☐
8. Visual loss or glaucoma	☐	☐	21. Kidney / Bladder infections	☐	☐
9. Night sweats, weight gain/loss	☐	☐	22. Reaction to general / local anesthesia	☐	☐
10. Cancer	☐	☐	23. Psoriasis / Skin Rash	☐	☐
11. Diabetes	☐	☐	24. Have you ever had Cortisone?	☐	☐
12. Hepatitis, jaundice or HIV	☐	☐	25. Do you smoke, how much? _____	☐	☐
13. Broken bones, where? _____	☐	☐	26. Do you drink alcohol? _____	☐	☐

Medications (Please include prescriptions, over the counter, and supplements):

MEDICATION	DOSE	# OF TIMES PER DAY

FAMILY HISTORY – Has anyone in your family had any of the following illnesses? Please include only brothers, sisters, parents and/or grandparents.

	CONDITION:	PERSON(S) AFFECTED
☐	Diabetes	
☐	Blood Clots	
☐	High Blood Pressure	
☐	Emphysema (or lung problems)	
☐	Osteoporosis	
☐	Lupus or other rheumatologic conditions	
☐	Heart issues	
☐	Anxiety/Depression	
☐	Cancer (site)	
☐	Other	

Signature: _____ Date: _____