



# EASTERN INDIANA ORTHOPAEDICS MEDICAL HISTORY FORM

APPOINTMENT DATE \_\_\_\_\_ ACCOUNT NUMBER \_\_\_\_\_

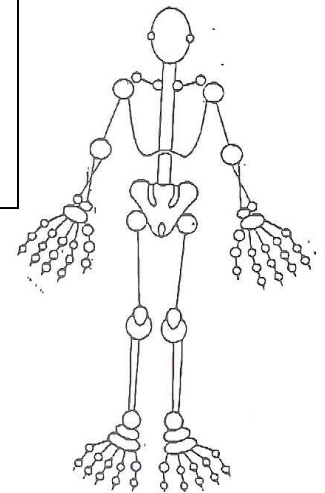
PATIENT NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_

WERE YOU SENT TO US BY ANOTHER PHYSICIAN? \_\_\_\_\_ IF SO, WHO? \_\_\_\_\_

PERSONAL PHYSICIAN \_\_\_\_\_

REASON FOR APPOINTMENT (Patient to complete) \_\_\_\_\_

FOR OFFICE USE	
HEIGHT _____ FT _____ IN	
WEIGHT _____ LBS	
PULSE _____	
XRAY _____	



## REVIEW OF SYSTEMS (that apply to you within the last six months)

Constitutional Symptoms (example: fever, weight loss)

Explain \_\_\_\_\_

Integumentary (Skin, rashes, sores, itching ulcers)

Explain \_\_\_\_\_

Cardiovascular (example: chest pain, palpitations)

Explain \_\_\_\_\_

Neurological (seizure, weakness, numbness, paralysis)

Explain \_\_\_\_\_

Respiratory (example: shortness of breath, cough)

Explain \_\_\_\_\_

Endocrine (Diabetes, Thyroid Disease)

Explain \_\_\_\_\_

Stomach/Intestinal (example: appetite, abdominal pain)

Explain \_\_\_\_\_

Ears, Nose, Throat (pain, lesions)

Explain \_\_\_\_\_

Musculoskeletal (osteoporosis, joint stiffness, cramping, muscle pain)

Explain \_\_\_\_\_

Hematologic/Immunologic (example: easy bruising, bleeding disorders) **Any** previous blood clots?

Explain \_\_\_\_\_

HIV/AIDS

Explain \_\_\_\_\_

All systems negative  yes

ROS Reviewed / Initialed \_\_\_\_\_

List all current medications, dosages, and condition prescribed for (use attached list if necessary)

Medication	Dose	Frequency	Condition Prescribed For
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medication allergies/reaction you had \_\_\_\_\_

Do you have a metal allergy \_\_\_\_\_

**PAST MEDICAL HISTORY**

Have you ever been treated for any of the following? If yes, please check.

- |   |                                    |   |
|---|------------------------------------|---|
| <input type="checkbox"/> High blood pressure        | <input type="checkbox"/> Diabetes  | Currently pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Heart Disease/Heart Attack | <input type="checkbox"/> Cancer    | Currently nursing <input type="checkbox"/> Yes <input type="checkbox"/> No  |
| <input type="checkbox"/> Emphysema/Asthma           | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hepatitis  |
| <input type="checkbox"/> Depression                 | <input type="checkbox"/> Ulcers    | <input type="checkbox"/> Immune Deficiency Disease                          |
| <input type="checkbox"/> Epilepsy                   | <input type="checkbox"/> Stroke    | <input type="checkbox"/> HIV/AIDS   |

Please comment on any illness checked above or write in other conditions \_\_\_\_\_

Have you ever had surgery before?  Yes  No Type of surgery and date \_\_\_\_\_

Are your immunization up to date (eg. Tetanus)? yes no

**FAMILY HISTORY**

Are there any diseases that run in your family (e.g. diabetes, rheumatoid arthritis, bleeding disorders, or anesthetic complications such as malignant hyperthermia)? \_\_\_\_\_

Have your parents or siblings had **your** current problem before? \_\_\_\_\_

**SOCIAL HISTORY**

- Marital Status  Married  Single  Divorced
- Children  No  Yes – Number \_\_\_\_\_ Ages \_\_\_\_\_
- I live  Alone  With Someone

Alcohol Use \_\_\_\_\_ If so, (circle amount) 1-6 6-12 12-18 >18 drinks per week

Tobacco Use \_\_\_\_\_ # of packs per day \_\_\_\_\_

Type of Work \_\_\_\_\_

**RELEASE OF INFORMATION**

I authorize release of my personal Health Care Information to the following person/number:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone number \_\_\_\_\_ Initials \_\_\_\_\_

**Office Use Only**

Physician Signature and Date Reviewed and/or Updated

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Additional Physician Comments

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_