LITTLE RIVER HEALTHCARE
GEORGETOWN ORTHOPEDICS

Patient Medical History

Patient Name: ________________________ Date of Birth: ________________

Height: ________ Weight: ________ Home Phone: ________________ Other Phone: ________________

PharmacyName/Location:____

Primary care physician: ____

Reason for today's visit: ____

____

When, where and how did the problem begin? ____

____

Is your injury/condition job-related? ☐Yes ☐No If yes, date of injury: ______________ (If your injury is to be covered by workman's compensation insurance, please provide all required information before your appointment. Failure to do so may invalidate your claim and cause charges to be your responsibility.)

Have you received any care elsewhere for this issue? If so, please explain: ________________

____

Were any X-rays, MRI's, CT scans, bone scans, or other diagnostic tests taken for this problem? If so, where can these be located? ____

____

Please list any allergies that you have to medications and the symptoms that you experience:

____

____

Are you allergic to ... Latex? ☐Yes ☐No Tape? ☐Yes ☐No Any medications? ☐Yes ☐No

Date of last Flu vaccine: ________________ Pneumonia vaccine: ________________

Social History:

Do you smoke cigarettes? ☐Yes ☐No Packs per day? __________

Do you drink alcohol? ☐Never ☐Occasional ☐Moderate ☐Heavy

Do you exercise? ☐Yes ☐No

What is your occupation? ________________________

What type of physical activity do you normally perform at work? ________________________

Past Medical History

Do you currently have, or have you had, any trouble with ... (check all that apply)

☐ Cardiovascular Disease ☐ Lung Disease ☐ Diabetes Type I or Type II ☐ Hepatitis
☐ High Blood Pressure ☐ Renal Failure ☐ Blood Clots or DVT ☐ Anemia
☐ Stomach Ulcers ☐ HIV ☐ Heart Failure

Date of last Colonoscopy: ________________ Where: ________________________________

Date of last Diabetic Labs: ________________ Where: ________________________________

Date of last Diabetic Eye Exam: ____________________ Where: __________________________

Family Medical History

Has anyone in your immediate family had trouble with any of the following? (check all that apply)

☐ Cardiovascular Disease ☐ Lung Disease ☐ Diabetes Type I or Type II ☐ High Blood Pressure
☐ Renal Failure ☐ Anemia ☐ Stomach Ulcers

Please list any major medical conditions not listed above: ______________________________

____

Please list past orthopedic surgical procedures and dates: ______________________________

____

Female Patients Only: Reproductive History

Are you pregnant? ☐ Yes ☐ No

Age you began menstruating? __________ When was your most recent menstrual period?______________

Have you experienced menopause or had a hysterectomy? ☐Yes ☐No

If yes, what & when? ____

Date of last mammogram ____

Review of Symptoms

Please check any of the following that apply to you:

☐ Recent weight change ☐ Double vision ☐ Fatigue/weakness ☐ Muscle weakness
☐ Stomach pain/heartburn ☐ Chest pain ☐ Skin rash ☐ Coughing up blood
☐ Joint stiffness,pain,swelling ☐ Swollen legs or feet ☐ Blood in Urine ☐ Speech Difficulties
☐ Easy bleeding or bruising ☐ Excessive Thirst ☐ Fever, chills ☐ Headaches ☐ Vomiting

______________________________ ______________________________

Patient/Guardian Signature Reviewed by

MR#______________