

EAST PORTLAND ORTHOPEDIC AND FRACTURE CLINIC

MEDICAL HISTORY

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ MALE/FEMALE DATE: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

REFERRED BY: \_\_\_\_\_ FAMILY PHYSICIAN: \_\_\_\_\_

PLEASE DESCRIBE THE PROBLEM AND SYMPTOMS YOU ARE SEEING THE DOCTOR FOR TODAY:
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

IS THE PROBLEM WORK RELATED? \_\_\_\_\_ WHEN DID THE PROBLEM BEGIN? \_\_\_\_\_

HAVE ANY TESTS BEEN DONE? X-RAYS \_\_\_\_\_ CT SCAN \_\_\_\_\_ MRI \_\_\_\_\_ EMG \_\_\_\_\_ OTHER \_\_\_\_\_

HAVE ANY TREATMENTS BEEN DONE FOR THIS PROBLEM? \_\_\_\_\_

PHYSICAL THERAPY \_\_\_\_\_ MEDICATION \_\_\_\_\_ CORTISONE INJECTIONS \_\_\_\_\_

PLEASE LIST ALL MEDICATIONS (PRESCRIPTIONS & NON-PRESCRIPTION) THAT YOU ARE PRESENTLY TAKING:

- 1. \_\_\_\_\_ 4. \_\_\_\_\_ 7. \_\_\_\_\_ 10. \_\_\_\_\_
2. \_\_\_\_\_ 5. \_\_\_\_\_ 8. \_\_\_\_\_ 11. \_\_\_\_\_
3. \_\_\_\_\_ 6. \_\_\_\_\_ 9. \_\_\_\_\_ 12. \_\_\_\_\_

LIST ALL ALLERGIES: \_\_\_\_\_

LIST ALL PAST SURGERIES (DATE IF KNOWN):
\_\_\_\_\_
\_\_\_\_\_

HAVE YOU HAD, OR DO YOU PRESENTLY SUFFER FROM: (Please circle all that apply)

- 1. Seizures/stroke YES NO [ ] [ ] 13. Ulcer/stomach bleed/indigestion YES NO [ ] [ ]
2. Angina, heart failure or attack [ ] [ ] 14. Thyroid disorder [ ] [ ]
3. Irregular heartbeat [ ] [ ] 15. Depression or anxiety [ ] [ ]
4. High blood pressure [ ] [ ] 16. Chemical dependency/alcoholism [ ] [ ]
5. Asthma/shortness of breath [ ] [ ] 17. Blood clots/phlebitis [ ] [ ]
6. Emphysema/chronic bronchitis [ ] [ ] 18. Bleeding disorder [ ] [ ]
7. Hearing loss [ ] [ ] 19. Difficulty voiding [ ] [ ]
8. Visual loss or glaucoma [ ] [ ] 20. Kidney/bladder infections [ ] [ ]
9. Night sweats, weight gain/loss [ ] [ ] 21. Reaction to general/local anesthetic [ ] [ ]
10. Cancer [ ] [ ] 22. Psoriasis/skin rash [ ] [ ]
11. Diabetes [ ] [ ] 23. Have you had cortisone? [ ] [ ]
12. Hepatitis, jaundice or HIV/TB [ ] [ ] 24. Do you smoke? How much? [ ] [ ]
25. Do you drink? How much? [ ] [ ]

Family History, circle if yes: Cancer - Diabetes - Heart Disease Who in family? \_\_\_\_\_

LIST ANY OTHER MEDICAL PROBLEMS NOT MENTIONED ABOVE:
\_\_\_\_\_
\_\_\_\_\_

Patient Signature

Date

Physician Signature