

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

Are you Pregnant? Yes No Maybe

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