Name: ______________________
Chart: ______________________
Date: ______________________

Height: __________ Weight: __________
BP: __________ Pulse: __________
Temp: __________

Medical History Form

Name: ______________________ DOB: __________ Age: __________ Gender: ☐ Male / ☐ Female
Referring Physician (Name/City): ______________________
Primary Physician (Name/City): ______________________ Send Today's Note: ☐ Yes / ☐ No
Occupation: ______________ ☐ Left / ☐ Right Handed Work injury? ☐ Yes / ☐ No Date of Injury: __________

Current Complaint

Chief Complaint: ______________________ ☐ Left / ☐ Right
When did the problem start? ______________ How did it start? ______________
Made better or worse by: ______________________
The body part is: Painful ☐ Yes / ☐ No Weak ☐ Yes / ☐ No Stiff ☐ Yes / ☐ No Swollen ☐ Yes / ☐ No Numb ☐ Yes / ☐ No
Any imaging (X-rays, MRI, CT)? Where and when done? ______________________
Additional info on current injury/problem: ______________________

CURRENT MEDICATIONS Please list **ALL** medications taken. ☐ None ☐ Medicine List Attached

Name of Medicine:	Dosage:	Name of Medicine:	Dosage:	Name of Medicine:	Dosage:

Allergies: ☐ None ☐ Latex **ALL ALLERGIES**:

____

Review of Systems: Please note ANY symptoms you have had **within the last SIX MONTHS**.

GENERAL		Swollen ankles	Yes / No	**HEMATOLOGICAL**	
Weight loss/gain (unintentional)	Yes / No	Shortness of breath	Yes / No	Blood clots	Yes / No
Chills	Yes / No	Wheezing	Yes / No	Bleeding disorder	Yes / No
Fever/Night sweats	Yes / No	Coughing	Yes / No	**PSYCH/NEUROLOGICAL**	
SKIN		**GENITOURINARY**		Seizures	Yes / No
Rash/Lesions	Yes / No	Frequent urination	Yes / No	Headaches/Migraines	Yes / No
HEENT		Blood in urine	Yes / No	Dizziness/Loss of consciousness	Yes / No
Hay fever	Yes / No	**GASTROINTESTINAL**		**LYMPHATIC**	
Visual problems	Yes / No	Indigestion	Yes / No	Swollen/Tender lymph nodes	Yes / No
Hearing problems	Yes / No	Nausea	Yes / No	**ENDOCRINE**	
CARDIO/PULMONARY		Vomiting	Yes / No	Hormonal irregularities	Yes / No
Chest pain	Yes / No	Vomiting blood	Yes / No	Blood sugar irregularities	Yes / No
Palpitations/Irregular heartbeat	Yes / No	Black stools	Yes / No		
		Constipation	Yes / No		
		Diarrhea	Yes / No		

Name: ____________________
Chart: ____________________
Date: ____________________

MEDICAL HISTORY Please circle diseases or disorders you have **EVER** been diagnosed with:

ADD	DVT (blood clot)	Liver disease	Stroke
Anemia	Emphysema	MRSA	Thyroid disease
Anxiety	Fractures	Osteoporosis	Tuberculosis
Asthma	Bone: ________	Poor circulation	Ulcers
Bipolar disorder	Glaucoma	Pulmonary embolism	Autoimmune/Rheumatologic disorders
Bleeding disorders	Gout	Reflux	TYPE: ________
Cancer	Heart attack	Renal failure	Other: ________
TYPE: ________	High BP	Dialysis: ________	________
Chemo/Radiation	Hepatitis A/B/C	Rheumatic fever	________
Depression	HIV	Schizophrenia	________
Diabetes I (insulin)	Kidney disease	Sleep apnea	**NONE**
Diabetes II	Kidney stones	Staph infection	

PAST SURGICAL HISTORY Please list any surgeries that you have had.

TYPE	YEAR	TYPE	YEAR	Orthopedic Surgeries	Right/Left	Year

FAMILY HISTORY Please indicate whether anyone in your immediate family has a history of the following:

Heart disease	Yes / No	Rheumatoid arthritis	Yes / No
Bleeding problems	Yes / No	Cancer	Yes / No
High blood pressure	Yes / No	Osteoporosis	Yes / No
Arthritis	Yes / No	Autoimmune disorder:	Yes / No
Diabetes	Yes / No	________	

SOCIAL HISTORY Marital status: Married / Divorced / Separated / Single / Widowed **LIVE WITH:** ____________

HABITS/RISK FACTORS

1. Tobacco use: ☐ Yes / ☐ No Quantity/day: _______ Cigarettes/Cigars/Chew/Vapor
   Used in past: ☐ Yes / ☐ No Started: __________ Stopped: __________
2. Recreational drug use: ☐ Yes / ☐ No Type and quantity per day/week: ____________
3. Have you been treated for overdose or addiction? ☐ Yes / ☐ No Are you on pain contract? ☐ Yes / ☐ No With whom: ________
4. Do you drink alcohol? ☐ Yes / ☐ No Type and quantity per day/week: ____________
5. Have you had a bone density scan? ☐ Yes / ☐ No When/Where?____________
6. In the past year have you had a flu vaccine? ☐ Yes / ☐ No
   Pneumonia vaccine: ☐ Yes / ☐ No
   Are you pregnant? ☐ Yes / ☐ No Due: __________

Patient/Parent/Guardian Signature: ____________________ Date: __________

Health Provider Signature: ____________________ Date: __________

Anchorage Fracture & Orthopedic Clinic complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.