Shoreline Orthopaedics

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MEDICAL HISTORY

Patient Name_____ **DOB**_____ **Date**_____

To help us meet your healthcare needs, please fill out both sides of this form completely. This is a confidential record of your medical history and will not be shared without your authorization.

Reason for Today's Visit: _____ **Hand Dominance:** ☐ **R** ☐ **L**

PAST MEDICAL HISTORY

☐ **No Past Medical History**

Please check any that apply.

- ☐ Arthritis/Type _____
- ☐ Back Pain
- ☐ Blood Disorder
- ☐ Bone Fractures
- ☐ Cancer/Type _____
- ☐ Depression/Anxiety
- ☐ Diabetes/Type _____
- ☐ Fibromyalgia
- ☐ GERD (reflux)
- ☐ Heart Condition/Disease
- ☐ Hepatitis/Liver Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Kidney Disease/Renal Insufficiency
- ☐ Lung Disease
- ☐ Osteopenia/Osteoporosis
- ☐ Pulmonary Embolism/DVT
- ☐ Sleep Apnea
- ☐ Thyroid Disease
- ☐ Other _____

PAST SURGICAL HISTORY

☐ **No Past Surgicial History**

Please list all operations you have experienced and indicate year they occurred.

- ☐ Back Surgery _____
- ☐ Bowel/Stomach Surgery _____
- ☐ Cancer Surgery _____
- ☐ Fracture/Bones _____
- ☐ Hand Surgery _____
- ☐ Heart Surgery _____
- ☐ Hip Surgery _____
- ☐ Joint Replacement _____
- ☐ Knee Surgery _____
- ☐ Neck Surgery _____
- ☐ Shoulder Surgery _____
- ☐ Other _____

MEDICATIONS

☐ **No Current Medications**

Please list all medications you are currently taking, prescribed and over the counter or provide a list.

Current Medication:	**Dosage:**	**How often per day?**

ALLERGIES

☐ **No Allergies**

Please list all allergies (Drug, Food & Environment) you have been diagnosed with and reaction.

Allergic To:	**Reaction:**	**Allergic To:**	**Reaction:**

FAMILY HEALTH HISTORY

Are you Adopted? ☐ Yes ☐ No

Please indicate if any **Blood Relative** has had any of the following:

Diagnosed With:	Yes	No	Relationship:	Diagnosed With:	Yes	No	Relationship:
Blood Disorder/Type _____	☐	☐	_____	High Blood Pressure	☐	☐	_____
Cancer/Type _____	☐	☐	_____	Kidney Disease	☐	☐	_____
Diabetes	☐	☐	_____	Lung Disease	☐	☐	_____
Heart Disease	☐	☐	_____	Mental Illness	☐	☐	_____

SOCIAL HISTORY

Do you use tobacco? ☐ Never ☐ Quit/Age _____ ☐ Yes, Type and how much per day? _____

Do you drink alcohol? ☐ Never ☐ Former ☐ Yes, How much? _____

Do you use illegal drugs? ☐ Never ☐ Former ☐ Yes

Do you drink caffeine? ☐ Never ☐ Former ☐ Yes

How much do you exercise? ☐ Sedentary ☐ 1-2 x/month ☐ 1-2 x/week ☐ 3-4 x/week ☐ Daily

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partner

What is your current occupation? _____

REVIEW OF SYSTEMS

Do you **currently have** or have you **recently had** any of the following?

Fever	☐ Yes	☐ No	Chronic Constipation	☐ Yes	☐ No
Chills	☐ Yes	☐ No	Blood in Stools	☐ Yes	☐ No
Weight Loss	☐ Yes	☐ No	Urinary Urgency	☐ Yes	☐ No
Weight Gain	☐ Yes	☐ No	Urinary Frequency	☐ Yes	☐ No
Eye Discharge	☐ Yes	☐ No	Painful Urination	☐ Yes	☐ No
Impaired Vision	☐ Yes	☐ No	Rash	☐ Yes	☐ No
Change in Vision	☐ Yes	☐ No	Itching	☐ Yes	☐ No
Frequent Headaches	☐ Yes	☐ No	Weakness	☐ Yes	☐ No
Vertigo	☐ Yes	☐ No	Incoordination	☐ Yes	☐ No
Lightheadedness	☐ Yes	☐ No	Loss of Balance	☐ Yes	☐ No
Frequent Sore Throat	☐ Yes	☐ No	Constant Thirst	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No	Anxiety	☐ Yes	☐ No
Rapid Heart Rate	☐ Yes	☐ No	Depression	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No	Easy Bleeding	☐ Yes	☐ No
Chronic Cough	☐ Yes	☐ No	Easy Bruising	☐ Yes	☐ No
Nausea	☐ Yes	☐ No	Enlarged Lymph Nodes	☐ Yes	☐ No
Vomiting	☐ Yes	☐ No	Skin Allergies	☐ Yes	☐ No
Chronic Diarrhea	☐ Yes	☐ No			