| MEDICAL INFORMATION SHEET | | Today's Date: | | | |
|--------------------------------|---------------------------------|---------------------------------------|------------------------|------------------|--|
| Name: | | Gender: M/F Date | of Birth: | Age: | |
| Family MD: | | Seasonal <i>or</i> Full time resident | | | |
| Reason for today's v | isit | | | | |
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| CC: | | | | | |
| HPI: | | | | | |
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| Past Medical History | | | | | |
| | t medical problems? If y | es, please circle any b | elow that apply. | | |
| Stroke | . , Heart Attack | Lung Disease | Heart Disease | Thyroid Disorder | |
| Kidney Disease | Vascular Disease | Ulcers | Neuro Disorders | Asthma | |
| Diabetes | Hypertension | Liver Disease | Cancer | Anemia | |
| Tuberculosis Blood transfusion | Hepatitis Other medical proble | Depression ems: | HIV/ AIDS | Blood clots | |
| Are these medical co | onditions under control? | Y/N | | | |
| | | | vo nama /# . | | |
| Do you see a special | ist for any of these cond | aitions: Y/N ii yes, giv | ve name/# : | | |
| <u>Allergies</u> | | | | | |
| Are you allergic to a | ny medications? Y/N I | f yes, to what? | | | |
| List the reaction | | | | | |
| Are you allergic to la | tex? Y/N | Any past reaction to an | esthesia? Y/N | | |
| List the reaction | | | | | |
| Surgical History | | Orthopaedic I | Orthopaedic History | | |
| <u>Procedure</u> | <u>Date</u> | Procedure | <u>Da</u> | <u>ate</u> | |
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| Family History | | | | | | |
|--|---|-------------------------------|--|--|--|--|
| Has anyone in your <u>immediate family</u> h | ad any of the following? List | the relative. | | | | |
| Diabetes | Heart Disease | | | | | |
| Stroke | Cancer – type | | | | | |
| Bleeding Disorder | Other | | | | | |
| N4000000000000000000000000000000000000 | | | | | | |
| Social History | | | | | | |
| Marital Status (optional please circle) | Single Married | Divorced Widowed | | | | |
| Occupation: | Height : V | Veight: | | | | |
| Do you smoke? Y/N If yes, how m | nany packs per day? pe | r week? per month? | | | | |
| If former smoker how long ago did you | quit? | | | | | |
| Do you drink alcohol? Y/N If yes, how often? Type of Alcohol: | | | | | | |
| Activities/Exercise: | | | | | | |
| For females: Are you pregnant? Y/N Are you planning pregnancy? Y/N | | | | | | |
| ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | - , - | • | | | | |
| REVIEW OF SYSTEMS | | | | | | |
| Do you have any of the following symptom | toms <u>right now</u> ? | ve none of these symptoms | | | | |
| Constitutional | Despiratory | Doughistria | | | | |
| <u>Constitutional</u> Loss of appetite | Respiratory Difficulty Breathing | <u>Psychiatric</u> Anxiety | | | | |
| Unexpected weight loss | Cough | Depression | | | | |
| Fever/Chills | Wheezing | Depression | | | | |
| Fatigue | Wileezing | | | | | |
| Eyes | Gastrointestinal | Hematological | | | | |
| Difficulty seeing | Abdominal Cramping | Bruising tendency | | | | |
| Recent changes in vision | Nausea/Vomiting | Bleeding tendency | | | | |
| | Heartburn | | | | | |
| Ear/Nose/Throat/Mouth | | | | | | |
| Nose Bleeds | <u>Musculoskeletal</u> | <u>Endocrine</u> | | | | |
| Difficulty Swallowing | Joint Pain or Stiffness | Heat/Cold intolerance | | | | |
| Recent chest cold | Joint Swelling | Excessive thirst | | | | |
| | Spasms | | | | | |
| <u>Cardiovascular</u> | Neurological | <u>Skin</u> | | | | |
| Chest Pain | Dizziness | Poor Healing | | | | |
| Irregular Heartbeat | Seizures | Rash | | | | |
| Swelling in the legs | Numbness | Ulcers | | | | |