

SCOTT ORTHOPEDIC CENTER INITIAL MEDICAL HISTORY

PATIENT'S NAME _____

WHY ARE YOU SEEING THE DOCTOR TODAY? _____

CHIEF COMPLAINT

WHAT ARE YOU ALLERGIC TO?

WHAT MEDICINES ARE YOU TAKING? (IF YOU HAVE A LIST, SKIP THIS PART AND GIVE THE LIST TO THE NURSE)

NAME OF MEDICINE	DOSAGE	HOW OFTEN?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

WHO IS YOUR PRIMARY CARE DOCTOR? _____

DO YOU HAVE ANY OF THESE CONDITIONS?

HEART PROBLEMS	YES	NO	CIRCULATION PROBLEMS	YES	NO
HIGH BLOOD PRESSURE	YES	NO	HEPATITIS OR JAUNDICE	YES	NO
DIABETES	YES	NO	OTHER (DESCRIBE)	_____	_____
ULCERS	YES	NO			
CANCER	YES	NO			
LUNG PROBLEMS	YES	NO			

REVIEW OF SYSTEMS

DESCRIBE PAST SURGERIES OR HOSPITALIZATIONS:

WHAT	WHEN
_____	_____
_____	_____
_____	_____
_____	_____

HISTORY

DO YOU SMOKE? YES NO

DO YOU NOW OR HAVE YOU EVER USED ILLEGAL DRUGS? YES NO WHAT? _____ WHEN? _____

SOCIAL HISTORY

WHAT ILLNESSES OR MEDICAL PROBLEMS RUN IN YOUR FAMILY? _____

FAMILY HISTORY

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE:

PATIENT OR GUARDIAN SIGNATURE _____ DATE _____

REVIEWED BY PHYSICIAN: _____ MD DATE _____