PEACHTREE ORTHOPEDICS

Patient Medical History Form

Name: _____ **Date:** _____

Date of Birth: _____ Age: _____ Pharmacy Phone: _____

Primary Care Physician: _____ Primary Care Phone _____

Referral Source: _____

Reason for today's visit: _____

Is this due to an injury: YES NO → If yes, date of injury _____

WC Claim: YES NO → Employer: _____

Motor Vehicle Accident: YES NO Represented by an attorney? YES NO

PLEASE MARK ALL CURRENT AND PAST HEALTH ISSUES:

Height: _____ **Weight:** _____

Anxiety Disorder:	YES	NO	Heart attack	YES	NO
Asthma	YES	NO	Hepatitis	YES	NO
Bipolar Disorder:	YES	NO	High Blood Pressure	YES	NO
Bleeding Tendency	YES	NO	Kidney Disease	YES	NO
Blood Clots	YES	NO	Kidney Stones	YES	NO
Cancer	YES	NO	MRSA	YES	NO
Cardiac Stents	YES	NO	Osteoarthritis	YES	NO
Cardiac Problems	YES	NO	Osteoporosis	YES	NO
Charcot Marie Tooth	YES	NO	Peripheral Neuropathy	YES	NO
Claustrophobia	YES	NO	Respiratory Problems	YES	NO
Currently Pregnant?	YES	NO	Rheumatoid Arthritis	YES	NO
Defibrillator/Pacemaker	YES	NO	Scoliosis	YES	NO
Depression	YES	NO	Seizure Disorder	YES	NO
Diabetes Type 1	YES	NO	Sleep Apnea w/ use of CPAP	YES	NO
Diabetes Type 2	YES	NO	Sleep Apnea, no CPAP	YES	NO
EDS and/or POTS	YES	NO	Stroke	YES	NO
Gout	YES	NO	Thyroid Disorder	YES	NO
HIV	YES	NO	Ulcers/GERD	YES	NO

PLEASE LIST ALL CURRENT MEDICATIONS (INCLUDING OVER-THE-COUNTER)

Name:	Dosage (if known):	Condition:	Name:	Dosage (if known):	Condition:

ALLERGIES:

Do you have any **DRUG** allergies? YES NO If yes, please list below to include the reaction:

Drug: _____ Reaction: _____ Severity: Mild Moderate Severe

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Do you have a **Latex Allergy:** YES NO Reaction: _____

Name: _____

PLEASE LIST ALL SURGERIES:

_____	Date: _____	_____	Date: _____
_____	Date: _____	_____	Date: _____
_____	Date: _____	_____	Date: _____

PLEASE LIST ALL SERIOUS ILLNESSES/ACCIDENTS:

_____	Date: _____	_____	Date: _____

FAMILY HISTORY:

Family Member	Age:	Health Issues? (Please list)	If deceased, age and cause of death:
Mother:			
Father:			
Brother/Sister:			
Brother/Sister:			
Son/Daughter:			
Son/Daughter:			

SOCIAL HISTORY:

Do you have an Advance Directive? YES NO

Smoking Status: [ ]Never [ ]Former [ ]Current every day [ ]Current some day [ ]Unknown

Smoking - How much? [ ]1 PPW [ ]2 PPW [ ]1/4 PPD [ ]1/2 PPD [ ]1 PPD [ ]2 PPD [ ]3+ PPD

Occupation: _____

Marital status: [ ]Unknown [ ] Married [ ]Single [ ]Divorced [ ]Widowed [ ]Domestic Partner

Alcohol intake: [ ]None [ ]Occasional [ ]Moderate [ ]Heavy

How many days in the past year have you had more than 4 drinks (female) or 5 drinks (male)? _____

Hand dominance: RIGHT LEFT Do you live alone or with others? ALONE OTHERS

Sporting Activities: _____

REVIEW OF SYSTEMS

Please answer each question with a YES or NO and add any relevant comments

General	Fever:	YES	NO	**Skin**	Rash	YES	NO
	Weight Gain	YES	NO	**Neurologic**			
	If yes, how much?	_____			Frequent/severe headaches	YES	NO
	Weight Loss	YES	NO		Dizziness	YES	NO
	If yes, how much?	_____			Trembling/Shaking(tremors)	YES	NO
Ear Nose Mouth Throat					Paralysis	YES	NO
	Teeth Abnormalities	YES	NO	**Psychiatric**			
	TMJ Pain	YES	NO		Memory lapse or loss	YES	NO
Cardiovascular				**Blood System**			
	Chest pain	YES	NO		Swelling in extremities	YES	NO
	Rapid or irregular heartbeat	YES	NO		Easy bleeding tendency	YES	NO
Respiratory					Easy bruising	YES	NO
	Chronic/persistent cough	YES	NO		Abnormal bleeding	YES	NO
	Shortness of breath	YES	NO		Past blood transfusion	YES	NO
Genitourinary				**Eyes**			
	Difficulty urinating	YES	NO		Currently wear glasses	YES	NO
	Blood in urine	YES	NO		Contact lens wearer	YES	NO
Musculoskeletal							
	Multiple fractures	YES	NO		Scoliosis	YES	NO