Coastal Orthopedics and Sports Medicine (Medical History)

Your Name: ____________________________ **Birth Date:** ___________ **Hand Dominance:** ☐ Right ☐ Left

1. I made the appointment today for my (pick one) ☐ Right ☐ Left : ☐ shoulder ☐ elbow ☐ hand ☐ neck ☐ upper back ☐ lower back ☐ hip ☐ knee ☐ ankle ☐ foot ☐ Other: ___________________________________

2. My Primary complaint is: ☐ pain ☐ deformity ☐ numbness ☐ weakness ☐ fracture ☐ Other: __________

3. I came here: ☐ Not having prior treatment ☐ Having tried treatment at home ☐ Referred from ER ☐ Sent in consultation from another physician: Name of physician: ____________________________________

4. I was injured at: ☐ Home ☐ Work ☐ School ☐ Playing Sports ☐ N/A ☐ Other: ______________________

5. Previous x-rays or MRI: ☐ Have been taken. ☐ Have not been taken.

6. Date of injury was _______________. If it was not an injury, when did your symptoms first appear? _________ days / weeks / months / years ago

7. Allergies: ☐ No known drug allergies ☐ Other: ____

8. Past Medical History (Check all that apply)

☐ Aids / HIV
☐ Arthritis
☐ Asthma
☐ Bipolar
☐ COPD/Emphysema
☐ Depression
☐ Diabetes, type I or II
☐ Heart Attack / Disease
☐ High Blood Pressure
☐ Ulcer
☐ Other: __________________________
☐ None Apply

9. Past Surgical History (Check all that apply)

☐ Appendectomy
☐ Bone and Joint Surgeries ______________________
☐ Gall Bladder Removal
☐ Heart Surgery or Cath. ________________________
☐ Hysterectomy
☐ Tonsillectomy
☐ Tubal Ligation
☐ No Previous Surgery
☐ Other: __________________________

10. Social History

Do you smoke? ☐Yes ☐ No
Have you in the past? ☐Yes ☐ No

Do you drink alcohol? ☐Yes ☐ No
Have you in the past? ☐Yes ☐ No

Do you exercise regularly? ☐Yes ☐ No
What is your job? ________________________

Is your faith / religion an important part of your life? ☐Yes ☐ No

Is prayer important to you? ☐Yes ☐ No

☐ Other: ________________________________

11. Family History (Check all that apply)

☐ History of Arthritis
☐ History of Heart Disease
☐ History of Osteoporosis
☐ History of Cancer
☐ History of Deformities
☐ Other: ____________
☐ None Apply

12. Medications (Fill in Medications) ☐ None Apply

____
____
____
____
____
____

Preferred Pharmacy: __________________________

13. Review of Symptoms (Check if you have recently had)

☐ Fever, Chills
☐ Neck Pain
☐ Chest Pain
☐ Shortness of breath with walking
☐ Short of breath-rest
☐ None Apply
☐ Blood in stools
☐ Rash
☐ Seizures
☐ Diabetes
☐ Depression
☐ Easy Bleeding

X ______________________________ ___________
Patient's or Guardian's Signature **Date**

______________________________ ___________
Physician or PA's Signature Date