OrthoWest, Ltd. • 7255 Old Oak Blvd C405 • Middleburg Heights OH 44130 • (440)816-5380

Adult Medical History Form

Chart: Age:
Prov:

Name_________________________ Date__________________

Physician (or person or place) that referred you to our office ________________________
Reason for Consulting an Orthopaedic Surgeon____________________________________
Is this a result of an injury? Yes No Date ____/_____/______
If yes, how did it happen?____
If Yes, where did it happen?____
Describe Side and Location (for example, right knee) _______________________________

Is this WORK RELATED? Yes No ? Was is reported to your work AND BWC? Yes No ?
Explain if needed____
When does it hurt (for example, at night, all the time, weight bearing, etc)______________
How long have you had the symptoms____
What are your symptoms, (for example, sharp pain)?_______________________________
Have you had any tests or xrays for this condition? Where?__________________________
Past serious injuries or accidents____
____
Have you missed work due to the injury? If so, list dates___________________________
Have your tried any other treatment? PT, Injections, Surgery, Medication? ____________

Major Operations or Illnesses

Hospital	Date	Reason

Conditions that run in your family (arthritis, diabetes, heart disease)___________________
____

Do you have or did you ever have:

Abnormal Bleeding	Diabetes	Kidney Disease	Recent Cold/Flu
AIDS (HIV)	Fever, Chills, Sweats	Liver Disease	Rheumatic Fever
Anemia	Glaucoma	Lung Disease	Sinus Problems
Arthritis	Headaches-Frequent	Marked Weight Loss	Stomach Troubles
Asthma	Heart Trouble	Nervous Disorder	Stroke
Blood Clots	Herpes	Pain in Jaw	Swollen Glands
Chemotherapy	High Blood Pressure	Radiation Treatment	Thyroid Disease
Convulsions/Epilepsy	Jaundice	Reaction to Anesthetic	Venereal Disease

Other:____

Medications (Can use back of page)

Medication	Dosage	Reason

List any allergies (and what is the reaction)_____________________________________
____
Do you smoke ? Y N If yes, how much____________ Quit? Years ago__________

Alcohol consumption per week_______________________

Height________ Weight__________(can estimate)
Advanced Directive Yes No Unsure
Contact Person Living Will / Phone ______________________

Office Use: Chart:
Last Name:
First Name:
Age: DOB: