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: