FAIR OAKS ORTHOPAEDIC ASSOCIATES, INC. MEDICAL HISTORY

Name: _____ **Date**: _____

Last First MI

Date of birth: _____ **Weight**: _____ **Height**: _____

Chief Complaint: _____ **Affected Side**: RT or LT **Date of Onset**: _____

Injury Related? YES / NO **Auto Accident**? YES / NO **Work Injury**? YES / NO

Dominant Side: RT Handed / LT Handed **Compensation Carrier**: _____

Alcohol Use? YES / NO Amnt: _____ **Tobacco Use**? YES / NO Amnt: _____

Please describe reason for visit: _____

_____

Past Medical History

Diabetes	YES/NO
Cancer	YES/NO
Ulcers	YES/NO
Depression/Nervousness	YES/NO
Blood Pressure	YES/NO
Lung Disease	YES/NO
Heart Problems	YES/NO
Past Blood Transfusion	YES/NO
Arthritis	YES/NO
Liver Disease/Hepatitis	YES/NO
Kidney Disease	YES/NO
VRE	YES/NO
MRSA	YES/NO

Review of Systems (Recent Problems)

GENERAL	Weight Loss/Fever/Chills	NONE
SKIN	Rashes/Sores/Swollen Nodes	NONE
HEART	Chest pain/Palpitations/Irregular Beats	NONE
LUNGS	Short of breath/Coughs/Bronchitis	NONE
G.I.	Gastritis/Nausea/Vomiting/Pain	NONE
G.U.	Painful urination/Leaking/Burning	NONE
MUSCLE	Joint pain/Swelling/Stiffness/Weakness	NONE
PSYCH	Anxiety/Depression/Addiction	NONE
BLOOD	Anemia/Abnormal Bleeding	NONE
ENT	Sinusitis/Hoarseness/Swallowing Problems	NONE
EYES	Vision Changes/Sensitivity to Light	NONE

Allergies/Reactions: _____

Family History: Do any of your blood relatives have or have had any of these diseases?

Diabetes	YES/NO	TB	YES/NO
Cancer	YES/NO	Thyroid Disease	YES/NO
Heart Problems	YES/NO	High Blood Pressure	YES/NO
Stroke	YES/NO		

Other: _____

Social History: Single Married Widowed Divorced Unknown

Past Surgeries: _____

_____

_____

Current Medications: _____

_____

_____

Signature: _____