Strategic Orthopaedics, LLC ~ Medical History

Today's Date _____

Last Name _____ First Name _____ MI _____
Date of Birth _____ Gender – M/F Age _____
Resident Address _____ City _____
State _____ Zip _____ email: _____

Phone: (H) _____ (C) _____ (W) _____
Occupation _____ Full-time/Part time
Employer _____
Address_____

Emergency Contact _____ Phone _____

Primary Care Provider (MD, DO, PNP) _____
Date (approximate) of last comprehensive exam _____

Social History

Do you use tobacco? Yes No
Amount _____/(day) (week)

Do you drink alcohol? Yes No
Amount _____/(day) (week)

Do you have supportive friends/family? Yes No

Do you have an active social life? Yes No

Do you participate in any hobbies or activities?
Yes No _____

Family History

Has anyone directly related to you ever had any of the following conditions? Please check all that apply.

Allergies _____
Anemia _____
Arthritis _____
Bleeding Disorder _____
Cancer _____
Diabetes _____
Digestive Disorder _____
Heart disease _____
Hypertension _____
Kidney Disorder _____
Neurological Disease _____
Osteoporosis _____
Stroke _____
Thyroid Disorder _____

Please complete both sides

Review of Symptoms

Do you have any of these symptoms? Please circle either Yes or No.

Constitutional			**Eyes**			**Ear, Nose and Throat**		
Fevers	Yes	No	Decreased vision	Yes	No	Loss of hearing	Yes	No
Weight gain	Yes	No	Cataracts	Yes	No	Sinus problems	Yes	No
Weight loss	Yes	No						
Heart/Vascular			**Lungs**			**Gastrointestinal**		
Chest pain	Yes	No	Shortness of breath	Yes	No	Stomach ache	Yes	No
Irregular heart beat	Yes	No	Wheezing	Yes	No	Diarrhea	Yes	No
Poor circulation	Yes	No	Persistent cough	Yes	No	Persistent vomiting	Yes	No
Stent	Yes	No	Home oxygen	Yes	No			
Genitourinary			**Musculoskeletal**			**Skin**		
Bloody urine	Yes	No	Joint swelling	Yes	No	Rash	Yes	No
Infections	Yes	No	Arthritis	Yes	No	Dry skin	Yes	No
Kidney stones	Yes	No	Fractures	Yes	No	Skin sores	Yes	No
Neurologic			**Psychiatric**			**Endocrine**		
Paralysis	Yes	No	Depression	Yes	No	Thyroid problems	Yes	No
Frequent headaches	Yes	No	Anxiety	Yes	No	Diabetes	Yes	No
Extremity numbness	Yes	No						
			Blood			**Nutrition**		
Allergies			Bleeding problems	Yes	No	≥ 3 Servings dairy/day	Yes	No
Allergies to food	Yes	No	Blood transfusions	Yes	No	≥3 Fruits/day	Yes	No
Environmental	Yes	No	Blood thinners	Yes	No	≥3 Vegetables/day	Yes	No

Please list any/all medications and dietary supplements that you are currently taking:

_____

_____

_____

Have you ever had surgery? Yes No If yes, please explain:

_____

_____

_____

Do you have a particular concern about your risk of developing certain diseases or conditions in the future? _____

_____

Is there anything else you would like to share or feel that we should know about your health history?

_____

_____

Signature _____ **Date** _____

Please complete both sides