Norton Orthopaedic Specialists
Medical History Intake Form

Patient Name: _____ **Date of Birth:** _____ **Age:** _____ **Date:** _____

_____ _____ ( )_____
Family Physician **Family Physician Address** **Physician Phone**

Who referred you to our Office? _____

_____ ( )_____
Referring Physician Address **Referring Physician Phone**

Height _____ Weight _____ Hand Dominance: Right Left

What are you here to see us for today? Right /Left _____

When did your problem start? _____ Is your problem work-related? Yes No

Have you seen another doctor for this problem? Yes No If yes, who? _____

Briefly describe how your injury occurred: _____

Please list any previous medical treatment for this problem _____

Please circle your current pain level: 0 1 2 3 4 5 6 7 8 9 10
Mild Moderate Severe

Please list any previous Orthopedic Problems or Broken Bones related to the current condition

Date	**Condition/Injury**	**Treatment (Surgery, Therapy)**
_____	_____	_____
_____	_____	_____

ALLERGIES

Are you allergic to any medications? Yes No

Please list: _____

Are you allergic to Latex? Yes No Are you allergic to anything else? Yes No Please list. _____

PAST MEDICAL HISTORY (Please check all current or previous medical Conditions)

____ Anemia	____ Diabetes	____ High cholesterol	____ Seizures
____ Arthritis	____ Emphysema	____ HIV	____ Stroke
____ Asthma	____ Heart disease	____ Irregular heartbeat	____ Alcoholism
____ Blood Clots	____ Liver disease	____ Immune system disease	____ Osteoporosis
____ Cancer	____ Hepatitis	____ Rheumatoid Arthritis	____ No Medical Problems
____ Depression	____ High blood pressure	____ Chemical Dependency	
____ Thyroid Disease	____Other _____		

Do you have a history of Peptic Ulcer Disease? Yes No Stomach Bleeding? Yes No

Have you ever had a blood clot? Yes No In your legs? Yes No In your lungs? Yes No

Female patients: Are you pregnant? Yes No Date of last menstrual period _____

Physician Signature _____ Date _____

PAST SURGICAL HISTORY (Please list all procedures with Date and Surgeon's name)

Surgical Procedure	Date	Surgeon

Please list ALL MEDICATIONS that you are currently taking (Including Vitamins, Supplements, and Herbs)

☐ **I AM ON NO MEDICATIONS**

Medication	Dosage	Reason for Medication

FAMILY MEDICAL HISTORY (Please check any conditions that run in your family)

____ Blood Clots ____ Diabetes ____ Hypertension ____ Cancer ____ Heart disease

____ Osteoporosis ____ Stroke/Seizures ____ Rheumatoid Arthritis ____ No Significant Problems

Please describe any other immediate family history of medical problems: _____

_____

SOCIAL HISTORY

Occupation _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Education: ☐ Grade School ☐ High School ☐ College ☐ Post Graduate

Tobacco Use: Yes No Type: _____ # per day: _____ Quit date: _____
Alcohol Use: Yes No Frequency: Daily ___ Weekends ____ Occasionally____ Other____
Drug Use: Yes No Type: _____ Frequency: _____

Exercise: ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never

Type of Exercise: _____

Do you have family/friends available to assist you at home if needed? Yes No

Do you have steps to enter your home? Yes No

Do you have bedroom & bathroom on main floor? Yes No

How far can you walk before taking a rest period? Less than 1 block 2 Blocks Half Mile No Limits

Physician Signature _____ Date _____

Current Health Problems (Please Circle all that Apply)					
General	Weight loss	Weight gain	Fatigue	Decreased appetite	
	Chills	Fever	Sweats	Sleeping Difficulty	No Problem
Eyes	Blurred vision/ Vision loss	Eye Pain	Glasses/ Contacts	Glaucoma	No Problem
Ear, nose, throat	Hearing loss	Dentures	Thyroid Enlargement	Throat pain	No Problem
	Inflammation	Canker Sores	Swollen Glands		
Cardiovascular	High cholesterol	Chest pain	Palpitations	Heart Murmur	No Problem
	Heart Attack	Aortic Aneurysm	Leg Swelling	Shortness of Breath	
Respiratory	Sleep Apnea	Tuberculosis	Pneumonia	COPD	No Problem
	Emphysema	Wheezing	Sputum/Phlegm	Coughing	
Gastrointestinal	Vomiting	Diarrhea	Hemorrhoids	Blood in Stool	No Problem
	Acid Reflux	Constipation	IBS	Stomach Ulcers	
Urinary	Blood in Urine	Incontinence	Bladder Infections Or Burning	Kidney Stones	No Problem
Endocrine	High Blood Sugar	Thyroid Disease	Menopause		No Problem
Musculoskeletal	Injury	Joint Pain	Muscle Pain	Swelling	No Problem
Skin	Color Change	Rash	Cellulitis/Infection	Breast Problems	No Problem
Neurologic	Dizziness	Fainting	Numbness	Stroke	No Problem
	Tingling	Headaches	Bad Balance	Trouble with Memory	
Hematologic/ Lymph	Leukemia	Anemia	Edema/ Swelling in legs	Bleeding Disorders	No Problem
Immunologic	HIV	AIDS	Hepatitis	Sexually Transmitted Disease	No Problem
Psychological	Depression	Anxiety	Mania	Personality Disorder	No Problem
Other:					

Physician Signature _____ Date _____