OrthoCarolina

Adult Medical History Form

Date of Visit: ______________________ **OC#:** __________________

Patient Full Name: ____ **Date of Birth:** __________ **Age:** ______

Who is your Primary Care Provider? ________________________________ **Gender:** ___

Pharmacy and Phone #: ____

Medical Conditions

☐ **None OR Write "P" for Past and "C" for Current Problem (Use other* if problem not listed.)**

___ Gout	___ Heart Disease	___ Bleeding Disorder	___ Cancer
___ Osteoarthritis	___ High Blood Pressure	___ Sickle Cell Trait/Disease	Type:____________
___ Rheumatoid Arthritis	___ High Cholesterol	___ Diabetes	Psychological Disorder:
___ Osteoporosis	___ Stroke	___ Thyroid Disorder	___ Depression
___ Scoliosis	___ Blood Clots / DVT	___ Liver Disease	___ Drug Abuse
___ Fracture / Broken Bone	___ Pulmonary Embolism	___ Hepatitis	___ Alcohol Abuse
___ Cerebral Palsy	___ Asthma	___ Ulcers / Reflux	Other: ___________
___ Dementia	___ Chronic Bronchitis	___ Kidney Disease	___ HIV / AIDS
___ Neuropathy	___ COPD	___ Pregnant	___ MRSA
___ Seizure Disorder	___ Anemia	___ Breastfeeding	Other:______________

List Drug Allergies and Reaction: ☐**None** ____

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List Current Medications (including dosage and frequency): ☐**None** ☐**See Attached List**

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List Any Past Surgeries and Date: ☐**None** ☐**See Attached List**

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Family History

☐**None** ☐ **Unknown/Adopted OR indicate if any of your blood relatives have had any of the following conditions**

☐Osteoarthritis	☐ Nerve Disorders	☐ Blood Disease	☐ Depression
☐Rheumatoid Arthritis	☐ Heart Disease	☐ Bleeding Disorder	☐ Cancer
☐Osteoporosis	☐ High Blood Pressure	☐ Diabetes	Type: ___________
☐Muscle Disorders	☐ Respiratory Disease	☐ Kidney Disease	☐ Other: ___________

Social History

Tobacco Use: ☐Non Smoker ☐ Former Smoker ____ Year Quit ☐ Current Smoker______# Packs/Day _____# Years

Alcohol Use: ☐Never ☐Rarely ☐ Weekly ☐ Daily

Marital Status: ☐Single ☐Married ☐ Divorced ☐ Widowed ☐ Other

Occupation:______________________________

Review of Systems

Indicate if you have current problems with any of the following:

Recurring Fever	Y N	Decreased Appetite	Y N	Excessive Thirst	Y N
Recent Weight Change	Y N	Difficulty Swallowing	Y N	Temperature Intolerance	Y N
Headaches	Y N	Heartburn	Y N	Skin Problems	Y N
Vision Problems	Y N	Nausea	Y N	Bleed Easily	Y N
Loss of Hearing	Y N	Vomiting	Y N	Bruise Easily	Y N
Hoarseness	Y N	Abdominal Pain	Y N	Joint Problems	Y N
Chest Pain / Discomfort	Y N	Blood in Stool	Y N	Dizziness	Y N
Heart Palpitations	Y N	Painful Urination	Y N	Convulsions	Y N
Difficulty Breathing	Y N	Increased Need to Urinate	Y N	Sleep Disturbances	Y N
Chronic Cough	Y N	Blood in Urine	Y N	Psychological Disorder	Y N

For Office Use Only:

Date Reviewed	Change? Y or N	Clinical Staff	Provider	Date Reviewed	Change? Y or N	Clinical Staff	Provider

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