



Past Medical History

Tallahassee Orthopedic Clinic is currently trying to make things easier for you the patient. Please fill the form out in its entirety.

Patient Name: _____ Male Female | New | Dr. Dewey
 Date of Birth : ___/___/___ Height: _____ | Est. Patient | Dr. Thornberry
 Referring Physician: _____ Weight: _____ | Consultation

Chief Complaint

What is the problem for which you are seeing the doctor? _____

History of Present Illness

When did your symptoms begin? _____
 How did your symptoms start? _____

Medical History *(please list your past medical history ex. diabetes, hypertension)*

Surgical History *(please list your past surgical history ex. cardiac stenting, hip replacement)*

Allergies *(to all medications, food, airborne particles, and any substance we might use in the operating room)*

Medications *(please list medications you are currently taking)*

Name	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History *(please list your family history ex. diabetes, stroke)*

Problem	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

Social History *(please list your social history ex. alcohol consumption, tobacco use)* Your Occupation _____

Are you married? Yes No
 Do you drink alcohol? None Minimal Moderate Heavy
 Do you smoke or chew tobacco? Cigarettes How much? _____
 Chew How much? _____

Review of Systems (please mark any medical problems that apply to you. If nothing is checked or written then the system will be noted as normal.)

General

- | | | |
|--|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> Activity Increase | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Other: _____ |

Eyes:

- | | | |
|-----------------------------------|----------------------------------|---------------------------------------|
| <input type="checkbox"/> Contacts | <input type="checkbox"/> Glasses | <input type="checkbox"/> Vision Loss |
| <input type="checkbox"/> Dryness | <input type="checkbox"/> Pain | <input type="checkbox"/> Other: _____ |

Ear, Nose, Mouth, Throat

- | | | |
|---|--------------------------------------|---|
| <input type="checkbox"/> Hearing Aids | <input type="checkbox"/> Ear aches | <input type="checkbox"/> Hearing loss |
| <input type="checkbox"/> Nasal Congestion | <input type="checkbox"/> Sinus Pain | <input type="checkbox"/> Partial Plates |
| <input type="checkbox"/> Mouth Pain | <input type="checkbox"/> Sore throat | <input type="checkbox"/> Other: _____ |

Respiratory

- | | | |
|--|--|---|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Chronic Bronchitis |
| <input type="checkbox"/> Pulmonary Embolus | <input type="checkbox"/> Other: _____ | |

Cardiac

- | | | |
|---------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Edema | <input type="checkbox"/> Heart Murmurs |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Other: _____ | |

GI

- | | | |
|---|------------------------------------|---|
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Change in bowel habits |
| <input type="checkbox"/> Loss of weight | <input type="checkbox"/> Nausea | <input type="checkbox"/> Other: _____ |

Musculoskeletal

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> Joint Inflammation | <input type="checkbox"/> Restricted Motion | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> Muscle Pain | <input type="checkbox"/> Muscle Spasm | <input type="checkbox"/> Other: _____ |

Neurological

- | | | |
|--------------------------------------|---------------------------------------|-----------------------------------|
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> "Black outs" | <input type="checkbox"/> CVA |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Head injury | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Head aches | <input type="checkbox"/> Other: _____ | |

Skin

- | | | |
|------------------------------------|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Abrasions | <input type="checkbox"/> Blisters | <input type="checkbox"/> Lacerations |
| <input type="checkbox"/> Rash | <input type="checkbox"/> Other: _____ | |

Psychiatric

- | | | |
|--------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Eating Disorder |
| <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Other: _____ | |

Endocrine

- | | | |
|---|---|--|
| <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Excessive hunger | <input type="checkbox"/> Excessive Urination |
| <input type="checkbox"/> "Hot flashes" | <input type="checkbox"/> Other: _____ | |

Hematologic, lymphatic

- | | | |
|--|--|--|
| <input type="checkbox"/> On anti-coagulants | <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Bruise Easily |
| <input type="checkbox"/> Blood clotting disorder | <input type="checkbox"/> Other: _____ | |