ocpn | raynham
ORTHOPEDIC CARE PHYSICIAN NETWORK
& REHABILITATION SERVICES

Medical History Form

Name _____Date: _____

Age _____ Gender: M___F___ Height_____ Weight_____lbs Lt____Rt___Handed?

Occupation (job description): _____

ls this a Worker's Compensation injury? ___Y ___N State? _____ Auto Accident? ___Y ___N
Were you referred by another doctor? ___Y ___N If so, who? _____
Reason for Today's Visit:_____

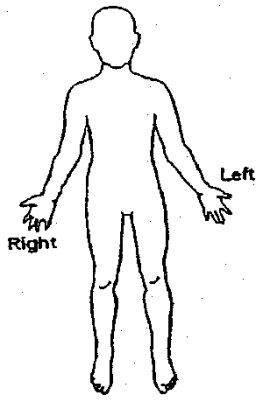
HISTORY OF INJURY

Please circle area of injury

Date of Injury/Start of problem: _____or Length in years _____
Pain Scale 1-10 (10 most painful): _____
Pain (circle all that apply):
Constant Occasional Sharp Dull Aching Stabbing Throbbing

Symptoms (circle all that apply): Swelling Locking Giving Way

What makes your symptoms better (rest, ice, medication, etc)?
_____
What makes you symptoms worse?_____
Have you tried any treatments for this (physical therapy, massage, injections)?
_____



FRONT

FAMILY HISTORY: (please check all that apply)

___Blood Clots ____Diabetes ____Hypertension ____Rheumatoid Arthritis ____Cancer ____Heart Disease ____Arthritis

REVIEW OF PATIENT SYSTEMS: (please check all that apply, or NONE if applicable)

GENERAL:	___NONE	___weight loss	___weight gain	___insomnia	___chronic fatigue
EYES:	___NONE	___vision changes	___cataracts	___ glasses or contacts	
ENT:	___NONE	___loss of hearing	___seasonal allergies	___sinus pain	
HEART.	___NONE	___chest pain	___high blood pressure	___palpitations	___edema
RESPIRATORY:	___NONE	___asthma	___wheezing	___frequent cough	
GI:	___NONE	___heartburn	___acid reflux	___peptic ulcer	
SKELETAL:	___NONE	___arthritis	___muscle weakness	___back pain	
NEUROLOGIC:	___NONE	___seizures	___headaches	___numbness	
PSYCHIATRIC:	___NONE	___depression	___mood swings	___anxiety	___frequent crying
ENDOCRINE:	___NONE	___diabetes	___hypothyroid	___hyperthyroid	
HEMATOLOGY:	___NONE	___easy bruising	___easy bleeding	___anemia	

PAST SURGICAL HISTORY: (please indicate procedure, date, and surgeon if available)

Arthroscopy Upper Extremity: _____

Arthroscopy Lower Extremity: _____

Joint Replacement: _____

Spine/Back Surgery: _____

Heart Surgery: _____

Other: _____

SOCIAL HISTORY:

Living Situation: ___ Alone ___With Spouse ___With Family ___Nursing Home Other: _____

Tobacco Use: Y___N___ Type: _____ How much daily: _____ How many years? _____

Alcohol: Y___N___ Frequency: ___Rarely ___Moderate ___Daily # of drinks per day_____

Drug use: Y___N___ Type and Frequency: _____

ALLERGIES: ___Penicillin ____Sulfa ____Latex _____Other Medication (please list)

___No Known Drug Allergies

MEDICAL HISTORY: (please check all that apply)

_____Asthma	_____ Emphysema/C OPD	_____ Kidney Problems
_____Bleeding Problems	_____ Fibromyalgia	_____ Osteoporosis
_____Cancer	_____ Heart Problems (type)	_____ Rheumatoid Arthritis
_____Chronic Back/Neck Pain	_____ Hepatitis	_____ Scoliosis
_____Degenerative/Osteoarthritis	_____ High Blood Pressure	_____ Stroke
_____Depression	_____ High Cholesterol	_____ Thyroid Disorder
_____Diabetes	_____ HIV	_____ Vascular Disease

Other: _____

MEDICATIONS: (please list all current medications)

Medication	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Any Current or Previous Steroid use (Prednisone?)

_____	_____	_____
_____	_____	_____

PHARMACY INFORMATION

Name: _____

Address: _____

Telephone: _____

Patient's Signature: _____ Date: _____

Reviewed by: _____ Date: _____

(OFFICE USE ONLY)