APPALACHIAN ORTHOPAEDIC ASSOCIATES, P.C.
PATIENT MEDICAL INFORMATION

DATE _____ Birthdate _____ Sex _____ Age _____

FULL NAME _____
First *Middle* *Last*

Referred to us by _____ Primary Care Physician _____

CURRENT COMPLAINT

_____

_____

_____

_____

_____

_____

HOW LONG HAVE YOU HAD THIS PROBLEM _____

IF YOUR PRESENT COMPLAINT IS THE RESULT OF AN ACCIDENT, PLEASE DESCRIBE THE ACCIDENT. GIVE EXACT DATE AND LOCATION (INCLUDING STATE).

_____

_____

_____

DATE FIRST OFF WORK DUE TO ACCIDENT OR ILLNESS.

_____

PAST MEDICAL HISTORY OF THE PATIENT

Yes	No	
		AIDS
		Alcoholism
		Anemia
		Arthritis
		Bleeding Disorders
		Cancer
		Diabetes
		Gout
		Heart Disease
		Hepatitis
		High Blood Pressure
		Kidney Trouble or Stones
		Liver Trouble
		Lung Disease
		Mental Illness
		Phlebitis
		Seizures
		Stomach Ulcers
		Stroke
		Thyroid Trouble
		Tuberculosis
		Other Illnesses

SURGERIES / PAST INJURIES (Approx. Dates):

_____

_____

_____

_____

_____

_____

_____

Current Medications and Dosage:

_____

_____

_____

_____

_____

Allergies to Medicine: (None ☐)

_____

_____

_____

FAMILY HISTORY

Yes	No	
		Alcoholism
		Arthritis
		Bleeding Disorders
		Cancer
		Diabetes
		Gout
		Heart Disease
		Hepatitis
		High Blood Pressure
		Kidney Trouble or Stones
		Mental Illness
		Seizures
		Stroke
		Tuberculosis
		Other

Cause of death of parents, or brothers, or sisters:

Parents: _____

Brothers: _____

Sisters: _____

SOCIAL HISTORY

Most Recent Occupation: _____

_____

Married ☐ Single ☐ Divorced ☐

Presently Living Alone? Yes ☐ No ☐

Smoke____ packs per day

Alcohol: Never ☐ Occasional ☐

Moderate to Heavy ☐

Drug Overuse: ☐ None ☐

Presently ☐ Past Problem ☐

IS PATIENT'S CONDITION RELATED TO:

A. Employment (Current or Previous?)
☐ **Yes** ☐ **No**

B. Auto Accident
☐ **Yes** ☐ **No**

C. Other Accident?
☐ **Yes** ☐ **No**

EXACT DATE OF ACCIDENT:

_____

REVIEW OF SYSTEMS
Have you recently had or do you now have:

Yes	No	
		Chest Pain
		Dizzy Spells
		Shortness of Breath
		Swelling in Arms / Legs
		Chills
		Fatigue
		Fever
		Weight Change
		Rashes
		Other Skin Disorders
		Diabetes
		Osteoporosis
		Thyroid Disease
		Colitis
		Heartburn
		Nausea
		Ulcers
		Frequent Urination
		Burning Urination
		Change in Vision
		Glaucoma
		Ear Pain
		Loss of Hearing
		Bleeding Problems
		Blood Clots
		Anemia
		Phlebitis
		Easy Bruising
		Arthritis
		Joint Pain
		Rheumatoid Arthritis
		Numbness / Tingling Arms / Legs
		Unsteadiness
		Weakness in Arms / Legs
		Blackouts
		Depression
		Anxiety
		Asthma
		Emphysema / Bronchitis
		Pneumonia

DO NOT WRITE BELOW THIS LINE

Physician: _____ Date: _____

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