FAIR OAKS ORTHOPAEDIC ASSOCIATES, INC. MEDICAL HISTORY

Name: ____________________ **Date**: ____________

Last First MI

Date of birth: ____________ **Weight**: ____________ **Height**: ____________

Chief Complaint: ____________ **Affected Side**: RT or LT **Date of Onset**: ____________

Injury Related? YES / NO **Auto Accident**? YES / NO **Work Injury**? YES / NO

Dominant Side: RT Handed / LT Handed **Compensation Carrier**: ____________

Alcohol Use? YES / NO Amnt: ____________ **Tobacco Use**? YES / NO Amnt: ____________

Please describe reason for visit: ____________________

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Past Medical History

Diabetes	YES/NO
Cancer	YES/NO
Ulcers	YES/NO
Depression/Nervousness	YES/NO
Blood Pressure	YES/NO
Lung Disease	YES/NO
Heart Problems	YES/NO
Past Blood Transfusion	YES/NO
Arthritis	YES/NO
Liver Disease/Hepatitis	YES/NO
Kidney Disease	YES/NO
VRE	YES/NO
MRSA	YES/NO

Review of Systems (Recent Problems)

GENERAL	Weight Loss/Fever/Chills	NONE
SKIN	Rashes/Sores/Swollen Nodes	NONE
HEART	Chest pain/Palpitations/Irregular Beats	NONE
LUNGS	Short of breath/Coughs/Bronchitis	NONE
G.I.	Gastritis/Nausea/Vomiting/Pain	NONE
G.U.	Painful urination/Leaking/Burning	NONE
MUSCLE	Joint pain/Swelling/Stiffness/Weakness	NONE
PSYCH	Anxiety/Depression/Addiction	NONE
BLOOD	Anemia/Abnormal Bleeding	NONE
ENT	Sinusitis/Hoarseness/Swallowing Problems	NONE
EYES	Vision Changes/Sensitivity to Light	NONE

Allergies/Reactions: ____________________

Family History: Do any of your blood relatives have or have had any of these diseases?

Diabetes	YES/NO	TB	YES/NO
Cancer	YES/NO	Thyroid Disease	YES/NO
Heart Problems	YES/NO	High Blood Pressure	YES/NO
Stroke	YES/NO		

Other: ____________________

Social History: Single ☐ Married ☐ Widowed ☐ Divorced ☐ Unknown ☐

Past Surgeries: ____________________

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Current Medications: ____________________

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Signature: ____________________