

Name: _____

Chart: _____

DOB: _____

_____ Date of Visit

JEWETT ORTHOPAEDIC CLINIC, PA

Medical History - Page 1

Age: _____ **Height:** _____ **Weight:** _____ **Primary Physician:** _____

Please note, items left blank indicate a negative response.

PAST MEDICAL HISTORY None Indicate **all** medical conditions you have experienced.

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Liver disorder | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Blood clots/DVT | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stomach ulcers | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Anemia | <input type="checkbox"/> Prostate enlargement | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Sleep apnea | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer | <input type="checkbox"/> Birth defects |
| <input type="checkbox"/> Asthma/Emphysema | <input type="checkbox"/> Thyroid disorders | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Other (list in space below) |

SURGICAL PROCEDURES: None Indicate **all** surgical procedures (include approximate dates).

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Tonsils _____ | <input type="checkbox"/> Heart _____ | <input type="checkbox"/> Uterus _____ | <input type="checkbox"/> Prostate _____ |
| <input type="checkbox"/> Appendix _____ | <input type="checkbox"/> Colon _____ | <input type="checkbox"/> Breast _____ | <input type="checkbox"/> Hernia _____ |
| <input type="checkbox"/> Thyroid _____ | <input type="checkbox"/> Gall bladder _____ | <input type="checkbox"/> Vascular _____ | <input type="checkbox"/> Other (list in space below) |

FAMILY HISTORY: None Indicate **all** medical conditions experienced by any parent, sibling, or child

- | | | | |
|-----------------------------------|--|---|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Birth defects |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Blood clots/DVT | <input type="checkbox"/> Anesthesia complications |

SOCIAL HISTORY:

- Occupation:** _____ Student Retired Disabled (when): _____
- Marital status:** Single Married Widowed Divorced
- Living alone:** Yes No with spouse with family with other: _____
- Tobacco use:** Never Current Previous
- Cigarettes packs per day: _____ number of yrs: _____ Quit when: _____
- Other frequency: _____ number of yrs: _____ Quit when: _____
- Alcohol use:** None Occasionally Weekly Daily Quit when: _____
- Beer Wine Liquor

REVIEW OF SYSTEMS: None Indicate **all** symptoms that you are presently experiencing.

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Fevers/Night sweats | <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Rashes |
| <input type="checkbox"/> Shaking/Chills | <input type="checkbox"/> Morning cough | <input type="checkbox"/> Stomach pain | <input type="checkbox"/> Severe itching |
| <input type="checkbox"/> Recent weight loss | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Blood in stools | <input type="checkbox"/> Bruising/Bleeding easily |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Coughing up blood | <input type="checkbox"/> Loose stools | <input type="checkbox"/> Calf cramps |
| <input type="checkbox"/> Frequent nosebleeds | <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Joint pain |
| <input type="checkbox"/> Visual problems | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Difficulty with urination | <input type="checkbox"/> Joint swelling |
| <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Abnormal heartbeat | <input type="checkbox"/> Pain/Burning on urination | <input type="checkbox"/> Loss of height |
| <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Ankle swelling | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Irregular periods |

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Medical History - Page 3

SUPERCONFIDENTIAL INFORMATION: None Indicate **all** conditions for which you have received treatment.

Mental health conditions (depression, anxiety, etc.)

HIV / AIDS

Substance abuse (alcohol, narcotics, ec.)

Sexually transmitted diseases (STD's)

Illegal drug use

Minor pregnancies (pregnancy under the age of 18)

If you have indicated any of the conditions above, **please initial** the corresponding categories listed below which will authorize **Jewett Orthopaedic Clinic** to disclose that information to third parties for treatment or payment purposes in the event that it is requested by said third parties or required by law

Initials: _____ Mental health information

Initials: _____ HIV/AIDS information

Initials: _____ Substance abuse information

Initials: _____ STD information

Initials: _____ Illegal drug use information

Initials: _____ Minor pregnancy information

Are you pregnant or could you be pregnant? No Yes If yes, due date: _____

I HAVE READ AND UNDERSTAND THE INFORMATION IN THIS CONSENT. I AM THE PATIENT OR AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING CONSENT TO THE ABOVE TERMS.

Print name of patient (or authorized representative)

Signature of patient (or authorized representative)

Date

Reason patient is unable to sign and representative's relationship to patient or authority to sign on behalf of patient

Name of Physician

Physician Signature

Date