Name: _____

DOB: _____

Chart: _____ _____
Date of Visit

JEWETT ORTHOPAEDIC CLINIC

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.

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

SURGICAL PROCEDURES:

☐ None Indicate **all** surgical procedures (include approximate dates).

☐ Tonsils _____	☐ Heart _____	☐ Uterus _____	☐ Prostate _____
☐ Appendix _____	☐ Colon _____	☐ Breast _____	☐ Hernia _____
☐ Thyroid _____	☐ Gallbladder _____	☐ Vascular _____	☐ Other (list in space below)

FAMILY HISTORY:

☐ None Indicate **all** medical conditions experienced by any parent, sibling, or child

☐ Cancer	☐ High blood pressure	☐ Kidney problems	☐ Osteoporosis
☐ Stroke	☐ Heart disease	☐ Bleeding disorders	☐ Birth defects
☐ Seizures	☐ Diabetes	☐ Blood clots/DVT	☐ 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 ☐ Previous ☐ Currently every day ☐ Currently some days

☐ Cigarettes packs per day: _____ number of yrs: _____ Quit when: _____

☐ Other: _____ 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.

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

Name: _____

DOB: _____

Chart: _____ _____
Date of Visit

JEWETT ORTHOPAEDIC CLINIC

Medical History - Page 2

MEDICATIONS: ☐ None List **all prescription** and **non-prescription** medications and **supplements**.

Name of medication	Strength/Dose	Frequency

ALLERGIES: ☐ None Indicate **all** allergies you have to **medications** and **foods.**

Include reaction, i.e. nausea, vomiting, itching, rash, swelling, difficulty breathing

☐ Penicillin _____
☐ Sulfa _____
☐ Aspirin _____
☐ Codeine _____
☐ Morphine _____
☐ Iodine _____
☐ Latex _____
☐ Milk _____

☐ Other - List below _____

Print name of patient (or authorized representative) _____ Signature of patient (or authorized representative) _____ Date _____

Name of Provider _____ Provider Signature _____ Date _____

Name: _____

DOB: _____

Chart: _____ _____
Date of Visit

JEWETT ORTHOPAEDIC CLINIC

Medical History - Page 3

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

☐ Mental health conditions (depression, anxiety, etc.)
☐ Substance abuse (alcohol, narcotics, etc.)
☐ Illegal drug use
☐ HIV / AIDS
☐ Sexually transmitted diseases (STD's)
☐ 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: _____ Substance abuse information
Initials: _____ Illegal drug use information
Initials: _____ HIV/AIDS information
Initials: _____ STD 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 Provider | Provider Signature | Date