Name:
DOB:
Chart:
Age:
Date:

OrthoConnecticut
World-class care, close to home.

MEDICAL HISTORY FORM

NAME: _____ DATE: _____

NAME OF PRIMARY CARE PHYSICIAN _____ PHONE # OF PCP: _____

Height: _____ Weight: _____

ARE YOU ALLERGIC TO ANY MEDICATIONS? ☐ YES ☐ NO

IF YES, PLEASE LIST ALL MEDICATION AND REACTIONS: _____

PLEASE LIST ALL MEDICATIONS YOU ARE TAKING: _____

PLEASE LIST ANY SURGERIES WITH DATES: _____

REVIEW OF SYSTEMS

Have you had or do you have an ulcer?	☐ YES	☐ NO
Are you pregnant at this time?	☐ YES	☐ NO
Do you have any respiratory conditions?	☐ YES	☐ NO
Are you diabetic?	☐ YES	☐ NO
Do you have any skin ulcers or rashes?	☐ YES	☐ NO
Do you have a history of seizures, strokes or headaches?	☐ YES	☐ NO
Do you have a history of depression or nervousness?	☐ YES	☐ NO
Are you Anemic?	☐ YES	☐ NO
Have you had recent weight loss or loss of appetite?	☐ YES	☐ NO
Have you had or do you have any heart conditions (including HBP)?	☐ YES	☐ NO

Do you have any other medical conditions not listed above?

FAMILY HISTORY: Have any blood relatives had any of the following disorders?

Diabetes ☐ YES ☐ NO High Blood Pressure ☐ YES ☐ NO

Arthritis ☐ YES ☐ NO Heart Disease ☐ YES ☐ NO

Social History:

Do you smoke? ☐ YES ☐ NO Packs per day? _____

Alcohol use? ☐ YES ☐ NO How often? _____

The information is true and correct to the best of my knowledge:

Signature: _____ Date: _____