Medical History Form

My present problem is:______________________First Began?__________ Right___Left___

If injured, how did it occur?____

Are you left/right hand :_____Ambidextrous___ Age_____Height:_____Weight:____

Have you had other injuries to the extremity being examined today? ___Yes___No When?_______
Describe the injury?____

Allergies to food or medication and type of reaction:________________________________
____

List all medications you take regularly or occasionally:

Name of medication: Dose:

____

____

Do you have any medical problems? If yes, please circle and give a brief description:

Heart
Lungs
Seizures
Kidneys, Bladder
Depression
Bleeding tendencies
Tendencies for infection
Exposure to hepatitis
Exposure to HIV infection (AIDS)
Exposure to TB infection

Have you had the usual childhood illnesses? ___Measles___Mumps___Chicken Pox___None

Have you ever used recreational drugs and if so what drugs?____________________________

Please list all surgeries you have had along with the dates and whether there were complications:

____

____

Do you smoke? ___Yes___No Packs per day_____for_____years.

Do you use alcohol? ___Yes___No ___Occasional use Drinks per day__________

Caffeine:___Yes___No ___Coffee___Tea___Soda Cups/cans per day_______

Present employer:____

Occupation:____

Patient Name:____Date:________________

EMPLOYMENT AND ACTIVITY HISTORY

If unemployed or retired, please complete the following. If not applicable, go to the next section:

Retired: ___Yes___No Since:______________________________

On medical leave: ___Yes___No Since:______________________________

Laid off: ___Yes___No Since:______________________________

On total disability: ___Yes___No Since:______________________________

SSD: ___Yes___No Next review:______________________________

My present or last job involved:

	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
Lifting	____________lbs.	____________lbs.	____________lbs.
Bending	____________	____________	____________
Twisting	____________	____________	____________
Sitting	____________hrs.	____________hrs.	____________hrs.
Standing	____________hrs.	____________hrs.	____________hrs.
Walking	____________hrs.	____________hrs.	____________hrs.
Driving	____________hrs.	____________hrs.	____________hrs.

My employer would allow me to return to work with restrictions:___Yes___No

Activities

What sports related physical activities or hobbies do you engage in:

___Aerobics
___Step aerobics
___Walking
___Golf
___Tennis
___Baseball
___Track
___Jogging
___Swimming
___Bicycle riding
___Karate
___Volleyball
___Basketball
___Football
___Weight Training
___Other:______________________________

Have you been limited in these activities:___Yes___No How:______________________________

Other hobbies or activities in which you have participated:______________________________

____

____

Do you have an attorney handling this accident or injury? ___Yes___No

Attorney's Name:____

Attorney's Address:____