# WATERBURY ORTHOPAEDIC ASSOCIATES, P.C.

## MEDICAL HISTORY

**NAME**________________________________________ **AGE**______________ **TODAY'S DATE**______________________

Are you left-handed right-handed _Male _Female Which doctor referred you to our office? _______________

Who is your primary doctor if different from the above? ___________________________________

**SOCIAL HISTORY**

Marital Status: **S / M / D / W** If you have children, what are their ages?___________________________

What sporting activities/hobbies do you engage in?_____________________________________________

Do you smoke? **Yes** **No** Packs per day _________ Do you drink alcohol? **Yes** **No** # drinks per week _______

**WORK HISTORY**

Are you employed? **Yes** **No** Employer's name____________________________________________.

Describe your job______________________________________________________________________.

How long have you worked for them?_______________. If you stopped working, when did you stop?______________.

If you are here for a work-related injury, please provide date of injury or date problem began __________________.

**CHIEF COMPLAINT**

Please describe your problem: ______________________________________________________________

_____________________________________________________________________________________

Have you had any treatment for this problem? (Medication, therapy, splints, etc.)

_____________________________________________________________________________________

**MEDICAL HISTORY**

Please list your current **medical conditions** (cancer, diabetes, hypertension, thyroid, ulcers, asthma, etc.):

1. ______________ 3. ______________ 5. ______________

2. ______________ 4. ______________ 6. ______________

Please list all **surgery** you have had. If you recall the date and doctor, please list them:

1. ______________ 3. ______________ 5. ______________

2. ______________ 4. ______________ 6. ______________

Please list your **current medications**. If you have a list, we will photocopy it

1. ______________ 3. ______________ 5. ______________

2. ______________ 4. ______________ 6. ______________

Do you have any **ALLERGIES TO MEDICATIONS**? **Yes** **No** If yes, please list

1. ______________ 3. ______________ 5. ______________

2. 4. 6.

WE WOULD LIKE TO ONCE AGAIN REVIEW YOUR PRESENT AND PAST MEDICAL HISTORY. PLEASE INDICATE BELOW IF YOU HAVE HAD DIFFICULTIES IN ANY OF THE FOLLOWING AREAS. **PLEASE ANSWER EACH QUESTION AND BRIEFLY EXPLAIN ANY "Yes" ANSWERS.**

| | | | |
|---|---|---|---|
| EYES | Y | N | ______________________________ |
| NOSE | Y | N | ______________________________ |
| HEADACHES / SEIZURES / STROKES | Y | N | ______________________________ |
| LUNGS/ASTHMA | Y | N | ______________________________ |
| HEART/HIGH BLOOD PRESSURE | Y | N | ______________________________ |
| STOMACH/ULCER/DIARRHEA | Y | N | ______________________________ |
| GALLBLADDER / LIVER | Y | N | ______________________________ |
| INTESTINES | Y | N | ______________________________ |
| URINARY TRACT | Y | N | ______________________________ |
| GYNECOLOGICAL DIFFICULTIES | Y | N | ______________________________ |
| DIABETES or THYROID | Y | N | ______________________________ |
| BROKEN BONES | Y | N | ______________________________ |
| ARTHRITIC JOINTS | Y | N | ______________________________ |
| VASCULAR or BLOOD VESSEL | Y | N | ______________________________ |
| BLEEDING OR EASY BRUISING | Y | N | ______________________________ |

OTHER______________________________________________________________

**PHYSICIAN NOTES** **DATE OF INJURY______________________**

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