DENVER METRO ORTHOPEDICS, P.C.
MEDICAL HISTORY FORM

Name: ______________________ **DOB:** __ / __ / ____ **Today's Date:** __ / __ / ____
Preferred Pharmacy: ____________________ **Pharmacy Phone:** ______________
Pharmacy Address: ____________________ **Pharmacy Fax:** ________________

Vitals (For Office Use Only): Height: ______ Weight: ______ BP: ______ Pulse: ______

List all prescriptions, over-the-counter medicines, and supplements you take regularly:

Medication:	Dose:	Frequency:	Medication:	Dose:	Frequency:

Do you have any allergies to medication, food, or environmental factors?

Allergic to:	Start Date:	Reaction:

History of Present Illness:

Which is your dominant side? ◻ Right ◻ Left ◻Ambidextrous
What are you being seen for today? ______________________ ◻ Right ◻ Left ◻ Both
When did your symptoms start? __________________ ◻ Gradually ◻ Suddenly ◻ Specific Injury
Is this a worker's comp injury? ◻ Yes ◻ No
Is this the result of an automobile accident? ◻ Yes ◻ No
Is there an attorney involved with this injury? ◻ Yes ◻ No
Please explain what happened: ____
____
____

What treatment have you tried for this condition?

Treatment Tried:	Treatment Start:	Frequency:	Effective Y/N

What tests have been performed for this condition?
X-RAY: When? ______________ Where? ______________________
MRI: When? ______________ Where? ______________________
CT: When? ______________ Where? ______________________
EMG: When? ______________ Where? ______________________
Have you missed time at work for this condition? ◻ Yes ◻ No
Have you injured this area before? ◻ Yes ◻ No Describe: ____________________
____

Past Medical History: □No Medical Problems

Y/N CVA (Stroke)
Y/N COPD
Y/N Coronary Artery Disease
Y/N Crohn's Disease
Y/N Depressive Disorder
Y/N Diabetes Mellitus Type I
Y/N Diabetes Mellitus Type II
Y/N Gout
Y/N Hepatitis
Y/N HIV
Y/N Hypertension (HBP)

Y/N Heart Attack (MI)
Y/N Osteoarthritis
Y/N Osteoporosis
Y/N Peptic Ulcer Disease
Y/N Peripheral Vascular Disease
Y/N Polio
Y/N Pulmonary Embolism
Y/N Reaction to Anesthesia
Y/N Rheumatoid Arthritis
Y/N Systemic Lupus
Y/N Sleep Apnea

Y/N Thyroid Disease
Y/N Weight Loss
Y/N Bleeding disorder
(Type: ______________________)
Y/N Clotting Disorder
(Type: ______________________)
Y/N Cancer
(Type: ______________________)
Other______________________
____
Y/N Could you be pregnant?

Surgical History:

Surgery or Procedure:	Date:

Family History:

Has any blood relative had any of the following? Check all that apply and list family member.

__**Bleeding Disorder**
(Type: __________________)
Family Member: _________
__**Clotting Disorder**
(Type: __________________)
Family Member: _________

__**Chronic Heart Disease**
Family Member: _________
__**Arthritis**
Family Member: _________
__**Diabetes (Type I/Type II)**
Family Member: _________

__**Reaction to Anesthesia**
Family Member: _________
__**Osteoporosis**
Family Member: _________
__**Cancer** (Type: _________)
Family Member: _________

Other: __________________

Social History:

Are you currently working? □ Yes □ No Current Occupation ______________________________

Marital Status: □ Single □ Engaged □ Married □ Divorced □ Widowed □ Live w/ Partner

Do you have children? □ Yes (How many? ____) □ NO

Do you smoke? □ Yes (Type/Frequency? ___________________) □ No □Quit (When? ____)

Do you use smokeless tobacco? □ Yes (Type/Frequency? _____________) □ No □ Quit (When? ____)

Do you drink alcohol? □ Yes (How much/Frequency? _______________) □No □ Quit (When? _____)

Do you use illegal drugs? □ Yes (Type/Frequency? ___________________) □ No □Quit (When? ______)

Do you have a prescription drug abuse history? □ Yes (Drug:___________________) □ No

How much exercise do you get? □ Yes (_____ times/week) □ Active, but no formal exercise □Sedentary

Review of Systems:

Do you currently have any of these symptoms?

Y/N Fever/Chills
Y/N Fatigue
Y/N Sleep Problems
Y/N Chest Pain

Y/N Fainting
Y/N Shortness of Breath
Y/N Cough
Y/N Heart Burn

Y/N Constipation
Y/N Nausea
Y/N Vomiting
Y/N Diarrhea
Y/N Joint Swelling

Y/N Cramps
Y/N Weakness
Y/N Numbness
Y/N Tingling

I certify that the information provided, herein, is true and correct to the best of my knowledge:

Signature ______________________________ Date ____________________