

Wake Orthopaedics, LLC

Patient Medical History

Date: _____

Chart # _____

Patient: _____

Wake Ortho Physician: _____

Primary Care Physician: _____

Referring Physician: _____

Please share with your healthcare provider, the activities you are most eager to resume following treatment:

I. Past Medical History: Please list any of the following that apply:

Injuries: _____

Operations (i.e. tonsillectomy): _____

Illnesses (i.e. diabetes): _____

Current Medications & Purpose: _____

Drug Allergies: _____

Please list any previous fractures: _____

Please list the date of your last Bone Density Test: _____

II. Social History:

Occupation: _____

Tobacco? YES NO Packs/day _____

Alcohol? YES NO Amount _____

Daily Activities (prior to injury): Independent _____ Require Assistance _____

Walking (prior to injury): Normal _____ Cane/Walker _____ Wheelchair _____

III. Family History: Does anyone in your immediate family (mother, father, siblings, children) suffer from any of the following? (Please identify which family member)

Heart Disease: _____

Cancer (type): _____

Diabetes: _____

Lung Disease: _____

Stroke: _____

Tuberculosis: _____

Alzheimer's: _____

Scoliosis: _____

Parkinson's: _____

Arthritis: _____

Seizures: _____

Multiple Sclerosis: _____

Rheumatoid/osteoarthritis: _____

IV. Please indicate if you have ever sought medical treatment for any of the following symptoms.

	YES	NO		YES	NO		YES	NO
Weight Loss	___	___	Vision	___	___	High Blood Pressure	___	___
Fever, chills	___	___	Hearing	___	___	Leg swelling	___	___
Appetite change	___	___	Skin rash/ bed sores	___	___	Low Blood Pressure	___	___
Joint Pain	___	___	Pneumonia	___	___	Chest pain	___	___
Muscle Pain	___	___	Fatigue	___	___	Fainting spells	___	___
Gout	___	___	Nausea	___	___	Shortness of breath	___	___
Headaches	___	___	Vomiting	___	___	Asthma	___	___
Redness/swelling of a joint	___	___	Diarrhea	___	___	Cough	___	___
Frequent falls	___	___	HIV	___	___	Memory loss	___	___
Seizures	___	___	Frequent urination	___	___	Heart Murmur	___	___
Stroke	___	___	Shingles	___	___	Kidney stones	___	___
Numbness	___	___	Anxiety	___	___	Anemia	___	___
Kidney Disease	___	___	TB	___	___	Blood clots	___	___
Hepatitis	___	___	Depression	___	___	Seasonal Allergies	___	___
Diabetes	___	___				Hallucinations	___	___
						Thyroid Disease	___	___

Patient/Guarantor Signature: _____

Date: _____

All items on this page were reviewed by _____ (MD/PA initials) on _____ (date).