

MID-MARYLAND MUSCULOSKELETAL INSTITUTE

Patient History Form

Patient Name _____ DOB _____ Age _____ Today's Date _____
Why are you seeing the doctor today _____ Date of Injury _____

Current problem is the result of [Please check all that apply]

Car / Truck accident Work accident Other _____

Current Medications	Dose	Reason for taking the medication
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies to Medication _____

Past Medical History

Surgical History

Prior Surgeries or Hospitalizations	Year	Complications
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever had general anesthesia NO YES
Any complications with anesthesia NO YES [if yes describe] _____

Review of Systems

Are you currently having or have you ever had problems with any of the following

	Circle	Describe all YES responses	Current Medications	Dose
Eyes, Ears, Nose Throat	NO YES	_____	_____	_____
Lungs, Breathing	NO YES	_____	_____	_____
Heart Burn, Digestion	NO YES	_____	_____	_____
Bladder Problems	NO YES	_____	_____	_____
Heart Disease / High BP	NO YES	_____	_____	_____
Diabetes or Sugar	NO YES	_____	_____	_____
Dizziness	NO YES	_____	_____	_____
Black out or Seizures	NO YES	_____	_____	_____
Depression	NO YES	_____	_____	_____
Cancer	NO YES	_____	_____	_____
Thyroid problems	NO YES	_____	_____	_____
Arthritis	NO YES	_____	_____	_____
Sleep Apnea	NO YES	_____	_____	_____

OTHER MEDICAL PROBLEMS _____

(OVER PLEASE)

Your Height _____ Your Weight _____

Are you currently taking any Blood Thinners? Please List: _____

Do you have cardiac stents? YES NO

Do you see any medical specialists (ie: Cardiologist, pulmonologist)? If so, please list specialty, condition, name, and phone number of physician.

What Over-the-Counter medications do you take, including herbal supplements? _____

If you are taking any weight loss products, please list: _____

Family History

Family Member	Alive or Deceased	Age	Health Status or Cause of Death
Grandmother [Mother's]	_____	_____	_____
Grandfather [Mother's]	_____	_____	_____
Grandmother [Father's]	_____	_____	_____
Grandfather [Father's]	_____	_____	_____
Mother	_____	_____	_____
Father	_____	_____	_____
Sister / Brother	_____	_____	_____
Sister / Brother	_____	_____	_____
Sister / Brother	_____	_____	_____
Sister / Brother	_____	_____	_____
Sister / Brother	_____	_____	_____
Sister / Brother	_____	_____	_____

Social History

Work in the home Employed [Occupation] _____ Student Retired

Single Married Divorced Separated Widowed

Children No Yes # _____ Do you live alone No Yes

Exercise Daily Weekly Monthly Rarely Never

What type of exercise _____

History of Substance Abuse No Yes What substance _____

Smoke No Yes # packs per day__ for _____ years Quit Smoking No YES [when] _____

Drink Alcohol Daily 1-2 per week 1-2 per month 1-2 per year

By signing this form you have acknowledge that you have answered this patient information sheet to the best of your ability to enable Mid-Maryland Musculoskeletal Institute to provide you with the highest quality of health care

Patient Signature: _____

Today's Date: _____ / _____ / _____

By signing this form acknowledges the Physician and/or Physician Assistant has reviewed the patients history and discussed appropriate findings with the patient.

Physician / Physician Assistant Signature: _____

Today's Date: _____ / _____ / _____