

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:

<input type="checkbox"/> Aerobics	<input type="checkbox"/> Swimming
<input type="checkbox"/> Step aerobics	<input type="checkbox"/> Bicycle riding
<input type="checkbox"/> Walking	<input type="checkbox"/> Karate
<input type="checkbox"/> Golf	<input type="checkbox"/> Volleyball
<input type="checkbox"/> Tennis	<input type="checkbox"/> Basketball
<input type="checkbox"/> Baseball	<input type="checkbox"/> Football
<input type="checkbox"/> Track	<input type="checkbox"/> Weight Training
<input type="checkbox"/> Jogging	<input type="checkbox"/> 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: _____