

Voytik Center for Orthopedic Care

MEDICAL HISTORY FORM

Name: _____ DOB: _____ Age _____ Male/Female Date: _____
Occupation: _____ Height: _____ Weight: _____
Family Physician: _____ Did your Family Physician refer you: Yes / No

Please describe the Problem and Symptoms you are seeing the doctor for today: _____

Rate your pain: No Pain 1 2 3 4 5 6 7 8 9 10 Worse Pain

*Date of Injury/Flare up date: _____

Is this problem/injury related to:

School _____ School Name: _____
Work _____ Employer: _____ Contact: _____ Phone#: _____
Auto _____ Has an **Attorney** been contacted? Yes / No If yes, Name _____ Phone#: _____
Home _____ Other: _____

Tests performed? _____ X-rays _____ CT Scan _____ MRI _____ EMG _____ Other _____

Physician(s) seen and treatment received: _____

MEDICATIONS: (Please list **ALL MEDICATIONS**. Prescription and over-the-counter)

1) _____ 2) _____ 3) _____
4) _____ 5) _____ 6) _____
7) _____ 8) _____ 9) _____

List **ALL ALLERGIES:** _____ Latex Allergy: Yes / No

List any **Family History of Disease:** _____

Social History: Married Single Number of Children: _____ Ages: _____

Do you use Alcohol: Yes No Do you Smoke: Yes No If Yes: How much _____

Review of Systems (have you had, or do you presently suffer from): if yes, check or circle all that apply.

- Seizure
- Heart problems
- Depression
- Chemical dependency
- Bleeding problems
- Hepatitis
- Psoriasis or other skin problems
- Stroke
- Psychiatric problems
- Anxiety
- Alcoholism
- Cancer
- Jaundice
- Thyroid problems
- Asthma
- High Blood Pressure
- Night Sweats
- Diabetes
- HIV
- Angina
- Sleep Apnea
- Blood Clots / Phlebitis
- Weight Gain / Loss
- Ulcer / GERD / Indigestion
- Reaction to general / local anesthesia

List any **Other Medical Problems:** _____

List **ANY Surgeries:** _____

Patient's Signature: _____ Physician's Signature: _____ Date: _____