Lancaster Orthopaedic & Sports Medicine
Patient Medical History

Patient Name:_____ DOB: _____ Age: _____ Sex: ___ M ___ F
Dominant Hand ___ R ___ L Height _____/_____ Weight _____ Problem Site: _____
When did it begin (date)? _____ Is this work-related? **__Y __ N** Is this due to an auto accident? **__Y __ N**
Have you ever had a problem like this before? **__ Y __ N** Are you a student? **__ Y __ N** Are you disabled? **__ Y __ N** Reason: _____
What is the main reason for today's visit? __Pain __Numbness __Weakness __Swelling __Stiffness ___Other
Who referred you to our office?_____ Who is your primary care physician? _____

PAST MEDICAL / SURGICAL HISTORY **Do you presently have or have you ever been diagnosed with any of these illnesses?**

☐High Blood Pressure ☐Diabetes ☐Stomach Ulcers ☐Cancer ☐Depression ☐Stroke
☐Heart Disease ☐Arthritis ☐Asthma ☐Blood Clots in legs ☐Kidney Disease
☐Liver disease ☐Problems with/Reaction to Anesthesia for surgery List Others:_____ ☐**NONE**

SURGERIES/HOSPITALIZATIONS: **List each type of surgery or reason for hospitalization and indicate the approximate year:**

_____ _____
_____ _____
_____ _____

SOCIAL HISTORY:
Do you have children? **___Y ___N** If yes, how many? ____ Are you pregnant or nursing? **___Y ___N** Marital Status: _____
Education: _____ Job/Occupation: _____ Employer: _____ Do you wear a seatbelt? **__Y __N**
Do you drink caffeine? __ None __ Moderate __ Heavy Have you ever had possible exposure to the AIDS virus? **__Y __N**
Do you smoke? **___ Y ___N** / ___ Cigarettes ___ Pipe/ # Years ___ If yes, how much do you smoke? ___ (pks/day)
Do you drink alcohol? **____ Y ____N** If yes, how many ounces / beers / drinks per day / week? _____
Have you ever used drugs or substances not prescribed by a healthcare provider? **__Y__N** If Yes, which drugs/substances? _____

MEDICATIONS: **Please list any medications you are currently taking, including over the counter, vitamins and herbal medications. Please bring these medications with you to each appointment.** ☐See attached list

Medication	Dosage	How often			Medication	Dosage	How often

ALLERGIES: ☐Penicillin ☐Aspirin ☐Sulfa ☐Codeine ☐Novocain ☐Iodine ☐Latex ☐No Known Allergies
List Other Allergies: _____ **PREFERRED PHARMACY:**_____

REVIEW OF SYSTEMS: **Do you presently have any of the following conditions? YES or NO must be circled.**

Y/N Headaches	Y/N Chest Pain	Y/N Numbness	Y/N Seizures	Y/N Problems Sleeping
Y/N Constipation	Y/N Watery Eyes	Y/N Indigestion	Y/N Weakness	Y/N Skin Ulcers
Y/N Joint Swelling	Y/N Fainting Spells	Y/N Blurry Vision	Y/N Joint Pain	Y/N Anxiety
Y/N Rashes	Y/N Cough	Y/N Weight Loss	Y/N Diarrhea	Y/N Wheezing
Y/N Incontinence	Y/N Leg Swelling	Y/N Shortness of Breath	Y/N Burning with urination	

FAMILY HISTORY: Check if any blood relatives have had any of the following and indicate relationship in the blank provided:
**** If there are no known conditions, please check this box.*** ☐**NONE**

☐ Stroke _____ ☐ Diabetes _____ ☐ Cancer _____
☐ Heart Attack _____ ☐ Kidney Disease _____ ☐ Leukemia _____
☐ Bleeding Tendency_____ ☐ Arthritis _____ ☐ High Blood Pressure _____
☐ Epilepsy _____ ☐ Emphysema_____ ☐ Tuberculosis_____
☐ Blood Clots _____ ☐ Sudden Death_____ ☐Colitis_____
☐ Rheumatic Heart Disease _____ ☐ Congenital Heart Disease_____
☐ Heart Failure_____ ☐ Problems with/Reaction to Anesthesia for surgery _____

****Please sign below stating the above information is accurate to the best of your knowledge.***

Patient Signature: _____ Date: _____