

Patient Information

For: _____ **DOB:** _____ **Patient Acct #:** _____

General Medical History

History of Present Illness (circle all that apply):

Primary care physician: _____ Referring Physician: _____

You are: R handed, L handed, Ambidextrous

Where are you having pain? _____

Is this a legal or third person liability case? No Yes Potential DATE Of INJURY: _____

Work Comp Motor Vehicle Accident Where did you get hurt? Home / School/ Work / Store/ Car

How did you get hurt? _____

Past Medical History/Conditions/Disease circle all that apply:

Anemia	Diabetes	Hypothyroidism	Poor circulation
Angina	Diabetic Foot Ulcers	Irregular heart beat	Pregnant? No Yes
Anxiety	Dialysis	Kidney failure	Pulmonary Embolism
Asthma	Diverticulitis	Liver problems	Reflux
Bleeding Disorder	Emphysema	LMP:	Rheumatoid
Blood clot	GI bleed	Lupus	Seizures
Cancer, type/status?	Heart attack	Migraines	Sleep Apnea
Chronic Back Pain	Hepatitis A,B,C	Neurological disorder	Stroke
Congestive heart failure	High Blood Pressure	Numbness/Tingling	Ulcers
Depression	HIV	Urinary tract infection	Other

Medications/Supplements or Over the Counter Drugs:

Name of medication	Strength/Dose	Reason for medication

Allergies to medications/medical equipment, YES or NO? If YES, list item & type of reaction it caused:

Surgical History:

Surgeries or Hospitalizations	Year	Complications (if any)

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Medical History: Overall level of physical health is: Excellent, Very Good, Good, Fair, Poor
Immunizations up-to-date? Y or N

Have you ever had any complications from surgery? Yes No

Have you ever had any problems with anesthesia? Yes No

If yes, describe: _____

Family History

Has anyone in your family had: (circle all that apply):

Diabetes, Heart Attack Female under age 65, Bleeding disorder, Anesthesia problem
Cancer, Rheumatoid arthritis, Osteoporosis Heart Attack Male under age 55

Social History

Marital status: circle: Single Married Divorced Separated Widowed

Children: Yes No

Do you live alone? No Yes If no, who do you live with? _____

Do you wear glasses or contacts? Yes or No, which one? _____

Occupation: _____

What kind of work?: Physical, Sedentary, Retired, Homemaker

Regular Duty Light Duty Off Work since _____ Reason: _____

Risk Factors:

Current smoker? No Yes, _____ # packs/day for _____ years

Quit smoking? This year over 1 year ago over 5 years ago over 10 years ago

Previously smoked? _____ #packs/day for _____ years

History of substance/drug abuse? No Yes, What? _____

Drink alcohol? No Occasionally Frequently

Exercise? Daily Weekly Monthly Rarely Never

What type of exercise? _____

Review of systems: Are you currently having or have you had problems with your:

Please circle all that apply and explain if necessary.

General health:	Fever/Chills	Fatigue	Sleep Problems
Eyes:	Blurry vision	Double vision	
Ears/Nose/Throat:	Decreased hearing	Sore throat	Ears ringing
Cardiovascular:	Chest pain	Fainting	
Respiratory:	Shortness of breath	Cough	
Gastrointestinal:	Heartburn	Constipation	Nausea/Vomiting/Diarrhea
Genitourinary:	Pain on urination	Incontinence	Increased frequency
Musculoskeletal:	Joint swelling	Cramps	Weakness
Dermatological:	Rash	Itching	
Neurological:	Numbness/Tingling	Loss of Balance	History of Seizures
Psychological:	Anxiety	Depression	
Endocrine:	Weight change	Thirsty all the time	
Hematology:	Easy bruising	Bleeding	Enlarged lymph nodes

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Other: _____

Patient Signature: _____ Date: _____

Reviewed by: _____ MD Date: _____

KSF Orthopaedic Center, PA

Welcome to our clinic today!

KSF is currently undergoing a transition to an electronic record system. In order to update your record in this new electronic system, you may be asked to fill out duplicate information about your medical history. This is to assure that the appropriate UPDATED information will be put into our system for all future visits. We apologize in advance for any delays you might experience.

Our ultimate goal is to achieve a much more efficient office visit experience for our patients. Once our system has been fully implemented we hope that you will find this to be the case.