**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#: ____________
Date of Auto Accident: ______________________ Is your visit today related to your accident? Yes / No
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: _________

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