Voytik Center for Orthopedic Care

Revised 01.30.19

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

List any **Other Medical Problems:** _____
List ***ANY*** **Surgeries**: _____
_____

*** **Please Note:** Any information provided above, can and will be submitted to your insurance company. Signing is consenting to do so***

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