COLUMBUS
ORTHOPEDIC & SPORTS MEDICINE
CLINIC
Columbus Community Hospital

Medical History Form

Patient#: _____ **Today's Date:** _____

Name: _____
First **MI** **Last**

Height: _____ **Weight:** _____ **I am:** ☐ **Right hand dominant** ☐ **Left hand dominant**

Family Physician: _____ **Pharmacy:** _____

Reason For Visit: Briefly describe the reason for your visit to our clinic: ☐ Left ☐ Right

_____

Medical History: Are you affected by any of the following? (Check all that apply) ☐ **NO MEDICAL PROBLEMS**

☐ Abnormal heart rhythm	☐ Diabetes	☐ Emphysema	☐ Liver disease
☐ Alcoholism	☐ Endometriosis	☐ Low back pain	☐ Kidney stone
☐ Anemia	☐ Gout	☐ Lung Disease	☐ Kidney failure
☐ Anorexia/Bulimia	☐ Heart Attack	☐ Osteoarthritis	☐ Thyroid disease
☐ Anxiety	☐ Heart Failure	☐ Osteoporosis	☐ Tuberculosis
☐ Asthma	☐ Hepatitis	☐ Ovarian cysts	☐ Depression
☐ Bleeding disorder	☐ HIV	☐ Rheumatoid arthritis	☐ Stroke
☐ Blood clots	☐ High Cholesterol	☐ Seizures	☐ Stomach Ulcers (GERD)
☐ Bronchitis	☐ Hypertension	☐ Irritable Bowel	☐ Lupus
☐ Schizophrenia	☐ Mentally challenged	☐ Migraines	☐ Fibromyalgia
☐ Drug Abuse	☐ Neuropathy	☐ Cancer (type_____)	
☐ Other _____		☐ Other _____	

SURGERIES: ☐ **NONE**

☐ Appendectomy	☐ Bladder surgery	☐ Back /Spine surgery	☐ C-Section
☐ Cardiac Bypass surgery	☐ Carpal tunnel release	☐ Gall Bladder Removed	☐ Hernia repair
☐ Hysterectomy	☐ Tonsillectomy	☐ Previous Fractures	

☐ Shoulder arthroscopy Rt. Lt. ☐ Knee Scope Rt. Lt.
☐ Rotator Cuff Repair Rt. Lt. ☐ Total Joint Replacement Rt Lt hip knee shoulder
☐ Foot/ankle surgery Rt. Lt. _____
☐ Other _____

FAMLY HISTORY:

Has anyone in your immediate family ever had any of the following?:

M=Mother F= Father S=Sister B=Brother GF= Grandfather GM = Grandmother

____Diabetes ____Osteoporosis ____Stroke ____Bleeding Disorder ____Genetic Disorder
____Cancer_____Type of Cancer ____Heart Attack ____High Blood Pressure
____ Malignant Hyperthermia

SOCIAL HISTORY:

A) Status: ☐ Single ☐ Married ☐ Widow ☐ Divorced ☐ Child

B) Current Work Status: ☐ Employed ☐ Part-time ☐ Full-time ☐ Unemployed ☐ Retired ☐ Self Employed ☐ Homemaker

Occupation: _____ Date of Employment_____

Employer: _____

☐ Full Duty ☐ Light Duty ☐ Off work ☐ Student, School Name: _____

☐ Disabled (Since_____) Reason: _____

C) Do you use tobacco products? ☐ No ☐ Yes If yes, how much and how long? _____

D) Do you consume alcohol? ☐ No ☐ Yes How much? _____

E) Do you exercise? ☐ No ☐ Yes Type & Frequency _____

F) Living Status: ☐ Alone ☐ With spouse ☐ With parents ☐ With roommate ☐ Assisted Living ☐ Nursing Home ☐ With Other _____

Medications: ☐ **NO MEDICATIONS**

List any prescriptions, drugs, and/or non-prescription medications and dosage, including vitamins, nutritional supplements, or anything taken orally. (Inform the nurse if you do not know how to spell the medication)

List Names of Medications:

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

ALLERGIES: ☐ **NO KNOWN MEDICATION ALLERGIES** **Are you allergic to latex?** ☐ **Yes** ☐ **No**

List Allergies:	***Describe reaction:***
1) _____	a) _____
2) _____	a) _____
3) _____	a) _____
4) _____	a) _____

FALL RISK ASSESMENT

1.	Do you have a history of falling? Have you fallen in the past 6 months?	**Yes**	**No**
2.	Have you been dizzy in the past 6 months?	**Yes**	**No**
3.	Use of ambulatory aids – ex. cane, crutches, walker, wheelchair, etc.	**Yes**	**No**
4.	Do you get dizzy when/after giving blood?	**Yes**	**No**

REVIEW OF SYSTEMS: Are you currently having or have you ever had problems with:

	Circle	**Explain yes answer**		**Circle**	**Explain yes answer**
Eyes	NO YES	_____	Bladder/Bowel Problems	NO YES	_____
Ears, Nose, Throat	NO YES	_____	Balance Problems	NO YES	_____
Lungs, Breathing	NO YES	_____	Numbness/Tingling	NO YES	_____
Digestion	NO YES	_____	Skin – Rashes/Open Sore	NO YES	_____
Mood/Sleep Problems	NO YES	_____			

Signature of staff entering Medical History Form _____