MID-MARYLAND MUSCULOSKELETAL INSTITUTE

Patient History Form

Patient Name _____ Today's Date _____

DOB _____ Age _____ Height _____ Weight _____

Why are you seeing the doctor today? _____ Date of Onset/Injury _____

Current problem is a result of [Please check all the apply]

☐ Car/Truck accident ☐ Work accident ☐ Other _____

Past Surgical History

☐ Gastrointestinal Surgery	☐ Orthopaedic Surgery	☐ Renal Surgery	☐ Thyroid Surgery
☐ Heart Surgery	☐ Pacemaker/ACID	☐ Spine Surgery	☐ Transplant
☐ Oncology Surgery	☐ Plastic Surgery	☐ Thoracic Surgery	

Have you ever had general anesthesia? ☐ Yes ☐ No Any complications? _____

Specify type(s) of surgery and date(s) _____

Do you have cardiac stents? ☐ Yes ☐ No

Are you currently taking any Blood Thinners? Please list: _____

List Current Medications (Including Prescription, Over the Counter, Herbal Supplements and any weight loss products)

Medication	Dose	Frequency

Allergies/Adverse Reactions _____

_____

Past Medical History

Are you currently having or have you ever had problems with any of the following?

☐ Anemia	☐ GERD/Reflux	☐ Kidney Disease	☐ Seizures/Epilepsy
☐ Anxiety Disorder	☐ Gout	☐ Leg or Foot Ulcers	☐ Skin Disease
☐ Arthritis	☐ Heart Attack	☐ Liver Disease	☐ Sleep Apnea
☐ Asthma	☐ Heart Disease	☐ Lung Disease	☐ Stroke
☐ Bleeding Disorder	☐ Heart Problems	☐ Migraines	☐ Thyroid Problems
☐ Blood Clots	☐ Hepatitis	☐ Osteoporosis	☐ Tuberculosis
☐ Cancer	☐ Hernia	☐ Pacemaker	☐ Ulcers
☐ Coronary Artery Disease	☐ HIV/Aids	☐ Peripheral Vascular Disease	☐ Urinary Tract Infections
☐ Depression	☐ Hypertension	☐ Pulmonary Embolism	☐ Others _____
☐ Diabetes	☐ Inflammatory Bowel Disease	☐ Rheumatoid Arthritis	_____

Social History

Occupation _____ Chewing Tobacco _____
Marital Status _____ History of Substance Abuse _____
Exercise Level _____ Number of Children _____
Smoking Status _____ Live Alone or With Others _____
Smoking How Much _____ Sporting Activities _____
Has Smoked Since Age _____ Hand Dominance _____
Alcohol Intake _____ Are you Currently Employed _____

Family History

Please include Rheumatologic problems

Family Member	Alive	Deceased	Age	Health Status or Cause of Death
Grandmother Maternal				
Grandfather Maternal				
Grandmother Paternal				
Grandfather Paternal				
Father				
Mother				
Sister/Brother				
Sister/Brother				
Sister/Brother				
Sister/Brother				

Patients Providers

Please list Current Providers of your Medical Care

Provider	Address	Phone/Fax

Patients Pharmacies

Pharmacies	Location	Phone

For Women Only

Last PAP Smear Date _____ ☐ Abnormal Last Mammogram Date _____ ☐ Abnormal
Date of last menstrual period or age of menopause _____ Age of first period _____
Number of Pregnancies _____ Births _____ Miscarriages _____ Abortions _____ Cesarean Sections _____

By signing this form you have acknowledge that you have answered this patient information sheet to the best of your ability to enable Mid-Maryland Musculoskeletal Institute to provide you with the higest quality of health care.

_____ _____
Patient Signature Today's Date

_____ _____
Doctor Signature Today's Date