Name:
DOB:
Chart:
Age:
Date:

# WATERBURY ORTHOPAEDIC ASSOCIATES, P.C.
## MEDICAL HISTORY

**FOR OFFICE USE ONLY**

**Vital Signs:**
Weight _____
Pulse _____
Respiration _____

**NAME** _____ **DATE** _____

**AGE** _____ **SEX** _____ ☐ **left-handed** ☐ **right-handed**

Which doctor referred you to our office? _____

Who is your primary care physician? _____

### SOCIAL HISTORY

Marital Status: ☐ S ☐ M ☐ D ☐ W If you have children, what are their ages? _____

What sporting activities/hobbies do you engage in? _____

Tobacco: ☐ Never ☐ Yes _____packs/day x_____years ☐ Quit ☐ Smokeless

Alcohol: Do you drink alcohol? ☐ Yes ☐ No # drinks per week_____

### WORK HISTORY

Are you employed? ☐ Yes ☐ No Employer's name _____.

Describe your job _____.

How long have you worked for them?_____. If you stopped working, when did you stop? _____.

If you are here for a work-related injury, please provide date of injury or date problem began_____.

### CHIEF COMPLAINT

Please describe your problem: _____

Have you had treatment for this problem? (Please list medications, therapy, splints, etc.)

### MEDICAL HISTORY

Please list your **MEDICAL CONDITIONS** (cancer, diabetes, hypertension, thyroid, ulcers, asthma, etc.)

| | | |
|---|---|---|
| 1. | 3. | 5. |
| 2. | 4. | 6. |

Please list all **SURGERY** you have had. If you recall the date and doctor, please list them:

| | | |
|---|---|---|
| 1. | 3. | 5. |
| 2. | 4. | 6. |

Please list your **CURRENT MEDICATIONS**. If you have a list, we will photocopy it.

| | | |
|---|---|---|
| 1. | 3. | 5. |
| 2. | 4. | 6. |

Please list all **ALLERGIES TO MEDICATIONS** and reactions they've caused. Include any allergies to eggs and shellfish.

| | | |
|---|---|---|
| 1. | 3. | 5. |
| 2. | 4. | 6. |

Name:
DOB:
Chart:
Age:
Date:

**FAMILY HISTORY**

Please indicate any family history: (cancer, diabetes, etc.)

WE WOULD LIKE TO ONCE AGAIN REVIEW YOUR PRESENT AND PAST MEDICAL HISTORY. PLEASE INDICATE BELOW IF YOU HAVE HAD DIFFICULTIES IN ANY OF THE FOLLOWING AREAS. **PLEASE ANSWER EACH QUESTION AND BRIEFLY EXPLAIN ANY "Yes" ANSWERS.**

| | | | |
|---|---|---|---|
| EYES | Y | N | |
| NOSE | Y | N | |
| HEADACHES/SEIZURES/STROKES | Y | N | |
| LUNGS/ASTHMA | Y | N | |
| HEART/HIGH BLOOD PRESSURE | Y | N | |
| STOMACH/ULCER/DIARRHEA | Y | N | |
| GALLBLADDER/LIVER | Y | N | |
| INTESTINES | Y | N | |
| URINARY TRACT | Y | N | |
| GYNECOLOGICAL DIFFICULTIES | Y | N | |
| DIABETES or THYROID | Y | N | |
| BROKEN BONES | Y | N | |
| ARTHRITIC JOINTS | Y | N | |
| VASCULAR or BLOOD VESSEL | Y | N | |
| BLEEDING or EASY BRUISING | Y | N | |

OTHER

**PHYSICIAN NOTES** **DATE OF INJURY**