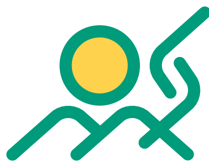

Boyette Orthopedics
& Sports Medicine, PA

Patient Medical History Form

2573 Stantonsburg Rd., Suite B
Greenville, NC 27834
Phone (252) 215-5200
Fax (252) 215-5201
info@boyetteorthopedics.com
www.boyetteorthopedics.com

Our Team: Working Together, Keeping You Active

Patient Information

Chart #: *(office use only)* ______________

Name: ______________________________ Birthdate: __________ SS#: ______________

Height: __________ Weight: __________ BMI: ________ Pulse: ________ Resp: ________ BP: __________

Primary Care Physician and Address: ____

____

Referring Physician(s) if other than Primary Care Physician and Address: ______________________

____

Referring Person if other than physician: ________________________________

Chief complaint: ____

____

Have other providers treated you for this condition? ◯ Yes ◯ No

If so, provide physician name and contact information: ________________________

____

Personal Medical Information

ARE YOU BEING TREATED FOR ANY OF THE FOLLOWING MEDICAL CONDITIONS? (Please circle all that apply)

- AIDS/HIV
- Alcohol Abuse
- Anemia
- Anesthesia Complications
- Arthritis
- Asthma
- Blood Clots
- Cancer
- Chronic Pain
- Connective Tissue Disease (e.g. Rheumatoid Arthritis, Lupus)
- COPD
- Defibrillator
- Dental
- Depression
- Diabetes
- Dialysis
- Drug Dependency/Addiction
- Fibromyalgia
- Gastrointestinal Disease
- Headache
- Heart Disease
- Hepatitis/Liver Disease
- High Blood Pressure
- High Cholesterol
- Implants (any and all)
- Infections
- Insomnia
- Kidney Disease
- Mental Health
- Osteoporosis
- Pacemaker
- Seizures
- Sleep Apnea
- Strokes/TIA
- TB
- Transfusion Reactions
- Ulcers
- Other: ______________________

____

____

____

continued

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Review of Symptoms

Please circle all that apply.

Blood
Anemia
Clots
Free Bleeder
Polycythemia (thick blood)

Cardiovascular
Chest Pain
History of Clots
Leg Swelling
Orthopnea
Palpitations
Syncope

Gastrointestinal
Anorexia
Bloating
Blood in Stool
Bulimia
Change in Appetite
Constipation
Diarrhea Pain
Heartburn
Nausea
Vomiting

General
Change in Diet
Fatigue
Fever
Night Pain
Weight Gain or Loss

Glands/Hormones
Cold intolerance
Heat intolerance
Menopause
Menstrual Irregularities
Weight Gain or Loss

Mental
Anxiety
Depression
Hallucinations (auditory, visual, tactile)
Insomnia
Suicidal Thoughts

Musculoskeletal
Night Pain
Pain
Stiffness
Swelling
Weakness

Neurological
Back Pain
Burning
Headache
Neck Pain
Numbness
Seizures
Tingling
Weakness

Ob/Gyn
Burning
Cramps
Dyspareunia
Itching
Menstrual Irregularities
Pregnancy
Urgency

Renal
Dialysis
Dysuria
Frequency
Incontinence
Stones
Urgency

Respiratory
Cough
Shortness of Breath
Sleep Apnea
Sputum

Skin
Bites
Bruising
Burns
Jaundice
Puritus
Rashes

Medications

LIST ALL OF YOUR CURRENT MEDICATIONS AND DOSES (Include over the counter, vitamins, herbal medications, CPAP machine, etc.)

______________________ ______________________ ______________________
______________________ ______________________ ______________________
______________________ ______________________ ______________________

Allergies

List medication and other allergies and your reaction. Please include food, tape, and latex allergies.

______________________ ______________________ ______________________
______________________ ______________________ ______________________
______________________ ______________________ ______________________

continued

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Family History

List all significant illnesses your grandparents, parents, brothers and sisters have had

Relative	Disease/Illness/Disorder	Relative	Disease/Illness/Disorder

Surgical History

Date	Operation	Date	Operation

Immunizations

Immunizations: ◯ Tetanus ◯ Flu ◯ Hepatitis ◯ Pneumonia

Ped's (up to date i.e.): ◯ MMR ◯ Polio ◯ Chicken Pox ◯ Other: ______________________

Social and Employment History

Employment Status: ◯ Full Duty ◯ Light or Modified Duty ◯ Disabled ◯ Retired ◯ Student

Job Description: ______________________ Employer: ______________________

Cigarette/Tobacco Use: (List packs per day, length of use): ______________________

Alcohol (List type and frequency of use): ______________________

Other Substances: ______________________

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Widowed

Hobbies/Sports/Exercise: ______________________

SIGNATURE OF PERSON FILLING OUT FORM ______________________ Date ____________

REVIEWED BY ______________________ Date ____________

Please complete this form and bring it with you at the time of your visit or fax it to Boyette Orthopedics & Sports Medicine at (252) 215-5201.