Anchorage Fracture & Orthopedic Clinic
The Strength of Experience

Medical History Form

For Office Use Only:
Patient ID #: _____
Height: _____ Weight: _____
BP: _____ Pulse: _____
Send today's chart note? ☐ Yes / ☐ No

Name: (Last) _____ (First) _____
Age: _____ Date of Birth: _____ Gender: ☐ Male / ☐ Female
Referring Physician (Name/City): _____
Primary Physician (Name/City): _____
Occupation: _____ ☐ Left / ☐ Right handed Work injury? ☐ Yes / ☐ No

History of Current Illness:

Chief Complaint (Why you sought care today): ☐ Left / ☐ Right _____
When did the problem start? _____ How did it start? _____
Made better or worse by: _____
The body part is: Painful ☐ Yes / ☐ No Weak ☐ Yes / ☐ No Stiff ☐ Yes / ☐ No Swollen ☐ Yes / ☐ No Numb ☐ Yes / ☐ No
Previous Images (X-rays, MRI, etc.): _____
Notes: _____

Current Medications: Please list medications. ☐ None

Name:	Dosage per day:	Reason:

Name:	Dosage per day:	Reason:

Allergies: ☐ None ☐ Latex Please list all allergies and reaction:

_____

Review of Symptoms: Please note any symptoms you've experienced within the past 6 months.

General:		**Pulmonary:**		**Hematological:**	
Weight loss (Unintentional)	Yes / No	Shortness of breath	Yes / No	Bleeding disorder	Yes / No
		Wheezing / asthma	Yes / No	Blood clots	Yes / No
Weight gain	Yes / No	Coughing up blood	Yes / No	**Psychiatric:**	
Chills	Yes / No	**Genitourinary:**		Depression	Yes / No
Fever	Yes / No	Frequent urination	Yes / No	Bipolar	Yes / No
Night sweats	Yes / No	Blood in urine	Yes / No	Schizophrenia	Yes / No
Skin:		Kidney stone	Yes / No	ADD	Yes / No
Rash	Yes / No	Urinary tract infection	Yes / No	**Endocrine:**	
Lesions	Yes / No	**Musculoskeletal:**		Thyroid problems	Yes / No
HEENT:		Rheumatoid arthritis	Yes / No	Liver disease	Yes / No
Hay fever	Yes / No	Osteoporosis	Yes / No	**Neurological:**	
Hoarseness	Yes / No	Bone tumor	Yes / No	Loss of consciousness	Yes / No
Visual problems	Yes / No	**Gastrointestinal:**		Headaches	Yes / No
Hearing problems	Yes / No	Indigestion	Yes / No	Dizziness	Yes / No
Cardiovascular:		Nausea	Yes / No	Seizures	Yes / No
Chest pain	Yes / No	Vomiting	Yes / No	**Lymphatic:**	
Palpitations	Yes / No	Vomiting blood	Yes / No	Lymph node swelling	Yes / No
Irregular heartbeat	Yes / No	Black stools	Yes / No	Node tenderness	Yes / No
Rheumatic fever	Yes / No				
Swollen ankles	Yes / No				

MD/PA Signature: _____ **Patient Signature:** _____ **Date:** _____

Name: (Last)_____ **(First)** _____ **Patient ID#:**_____

Medical History: Please indicate diseases or disorders you have now or experienced in the past.

Anemia	Yes / No	Dialysis	Yes / No	High cholesterol	Yes / No
Anxiety	Yes / No	Emphysema	Yes / No	Kidney stones	Yes / No
Arthritis	Yes / No	Fractures	Yes / No	Poor circulation	Yes / No
Asthma	Yes / No	Bone: _____		Pulmonary embolism	Yes / No
Bleeding disorder	Yes / No	Glaucoma	Yes / No	Reflux	Yes / No
Cancer	Yes / No	Gout	Yes / No	Renal failure	Yes / No
Type: _____		Heart attack	Yes / No	Sleep apnea	Yes / No
Chemotherapy	Yes / No	High blood pressure	Yes / No	Staph infection	Yes / No
Diabetes I	Yes / No	Hepatitis A	Yes / No	Stroke	Yes / No
(taking insulin)	Yes / No	Hepatitis B	Yes / No	Thyroid disease	Yes / No
Diabetes II	Yes / No	Hepatitis C	Yes / No	Tuberculosis	Yes / No
Are you taking insulin?	Yes / No	HIV	Yes / No	Ulcers	Yes / No
DVT (blood clot)	Yes / No			Other: _____	

Past Surgical History: Please indicate operations you have had.

Type:	**Year:**			**Other Operations:**	**Year:**
Heart bypass	_____	Spine surgery	_____	_____	_____
Pacemaker	_____	Hip surgery		_____	_____
Heart valve	_____	☐ Right ☐ Left ☐ Both	_____	_____	_____
Heart stent	_____	Knee surgery		_____	_____
Cancer surgery	_____	☐ Right ☐ Left ☐ Both	_____	_____	_____
Prostate surgery	_____	Shoulder surgery			
		☐ Right ☐ Left ☐ Both	_____		

Family History: Please indicate whether anyone in your immediate family has ever experienced any of the following:

Heart disease	Yes / No	Arthritis	Yes / No
High blood pressure	Yes / No	Cancer	Yes / No
Bleeding problems	Yes / No	Osteoporosis	Yes / No
Diabetes	Yes / No	Other _____	

Social History:

- Marital status (circle one): Married / Divorced / Separated / Single / Widowed
- Live with (circle all that apply): Alone / Spouse / Children / Parents / Mother / Father / Guardian / Roommate / Partner

Habits/Risk Factors:

- Do you use tobacco? ☐ Yes / ☐ No Type and quantity/day: _____
- Have you used tobacco in the past? ☐ Yes / ☐ No Dates: _____
- Do you use recreational drugs? ☐ Yes / ☐ No Type and quantity/day: _____
- Have you been treated for overdose or addiction? ☐ Yes / ☐ No Dates: _____
- Do you drink alcohol? ☐ Yes / ☐ No Type and quantity/day: _____

Have you ever had a bone density scan? ☐ Yes / ☐ No When? _____

Females: Are you pregnant? ☐ Yes / ☐ No Due Date: _____

Patient/Parent/Guardian Signature:_____ Date:_____

Health Provider Signature: _____ **Date:**_____