ANIMAS ORTHOPEDIC ASSOCIATES and SPORTS MEDICINE
an office sharing agreement

# General Medical History Worksheet

***Check boxes and fill in information as appropriate***

Name: _____ Date of Birth: _____ Date: _____

Who are your primary doctor(s) to whom reports should be sent? _____

**Past Medical History**

| | | | |
|---|---|---|---|
| ☐ Diabetes/High Blood Sugar | ☐ High Blood Pressure | ☐ Heart Attack/Heart Disease | ☐ Lung Disease/Emphysema (explain): _____ |
| ☐ Arthritis | ☐ Sleep Apnea | ☐ Gout | ☐ Prior Fractures/Broken Bones (explain):_____ |
| ☐ Varicose Veins | ☐ Thyroid Disease | ☐ Psychiatric Problems | ☐ Inflammatory Arthritis (Rheumatoid, Lupus, Psoriatic, Spondylitis) |
| ☐ Fibromyalgia | ☐ Stroke/T.I.A. | ☐ High Cholesterol | ☐ Bowel and GI Problems (explain): _____ |
| ☐ Urinary Tract Infections | ☐ Anemia/Hemophilia | ☐ Blood Clot/Deep Vein Thrombosis | ☐ Serious Infections (explain): _____ |
| ☐ HIV/AIDS | ☐ Breast Disease | ☐ Poor Circulation or Vascular Disease | ☐ Sexually Transmitted Disease (explain): _____ |
| ☐ Prostate Disease | ☐ Multiple Sclerosis | ☐ Eating Disorder/Poor Nutrition | ☐ Skin Disease (explain): _____ |
| ☐ Kidney Disease | ☐ Anesthesia Problems | ☐ Gastric Ulcers | ☐ Hepatitis ("Jaundice")/Liver Disease |

Cancer History (type and current status):_____

Other Medical Problems:_____

**Prior Hospitalizations and Surgical History** ☐ No Past Medical History

| | Type of Surgery/Reason for Hospitalization | Date | Surgeon/Physican |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |

**Current Medications (include herbal supplements and attach sheet if necessary)** ☐ Taking No Medication

| | Name of Medication | Dose/Strength | Schedule Taken |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |
| 7. | | | |

**Allergies to Medication or Materials** ☐ None Known

| | Allergen | Reaction |
|---|---|---|
| 1. | | |
| 2. | | |

**Social Background**

Marital Status: □ Married □ Domestic Partnership □ Single □ Divorced □ Widowed

Age(s) of children: _____ Can someone care for you at home? □ No □ Yes who? _____

Do you drink caffeinated beverages? □ No □ Yes If so, how much per day?_____

Do you have a history of illicit drug use? □ No □ Yes If so, explain:_____

Do you use tobacco? □ No □ Yes If so, how much/ packs per day? _____ How many years?_____

Previously used tobacco? □ No □ Yes If so, did you quit □ 1 year ago □ > 5 years ago □ > 10 years ago

Do you drink alcohol? □ No □ Occasionally □ Daily How much?_____

**Family Medical History**

| Relation | Age | State of Health | Age of Death | Medical Problems or Cause of Death |
|---|---|---|---|---|
| Mother | | | | |
| Father | | | | |
| Sibling □Bro □Sis | | | | |
| Sibling □Bro □Sis | | | | |
| Sibling □Bro □Sis | | | | |
| Grandfather (maternal) | | | | |
| Grandmother (maternal) | | | | |
| Grandfather (paternal) | | | | |
| Grandmother (paternal) | | | | |

**Review of Systems:** Are you currently having or have you had problems with:

| Condition | Check a Box | Please Describe all "Yes" Responses |
|---|---|---|
| Fever or Shaking Chills | □ No □ Yes | |
| Weight Loss (not Diet related) | □ No □ Yes | |
| Chest Pain | □ No □ Yes | |
| Lung or Breathing Problems | □ No □ Yes | |
| Irregular Heart Beat | □ No □ Yes | |
| Problems Urinating | □ No □ Yes | |
| Loss of Strength or Numb/Tingling | □ No □ Yes | |
| Bowel or Stool Problems | □ No □ Yes | |
| Headaches | □ No □ Yes | |
| Vision Problems | □ No □ Yes | |
| Skin Issues | □ No □ Yes | |
| Pregnancy or Menstrual Problems | □ No □ Yes | |
| Lumps or Masses (incl. Breast) | □ No □ Yes | |
| Fainting/Seizures/Blackout | □ No □ Yes | |
| Bleeding or Blood Clots | □ No □ Yes | |
| Psychiatric Issues | □ No □ Yes | |
| Problems with Anesthesia | □ No □ Yes | |
| Ears, Nose or Throat | □ No □ Yes | |

**X**_____ _____ **X**_____

Signature of Patient, Parent, or Guardian Date Reviewed by MD