

**ORTHOPEDIC GROUP OF BIRMINGHAM, P.C.
HEALTH HISTORY**

Name: _____ Age _____ Were you referred by a Physician: yes ___ no ___

Who requested our services? _____ Family Physician _____

Reason for seeking medical attention: _____ Right Left Both

Date of injury or duration of symptoms _____ Where did accident/injury happen? _____

Work Related? ___Yes ___No Automobile Accident? ___Yes ___No

Are you right or left handed? Right Left Are you pregnant? Yes ___ No ___

Have you had any diagnostic studies for this condition such as MRI, Bone Scan, etc? Please List _____

Have you seen anyone else regarding this condition? Yes___ No___ If yes, list names and dates

Have you ever been diagnosed with any of the following medical conditions:

	Yes	No		Yes	No		Yes	No
Asthma	___	___	Rheumatoid Arthritis	___	___	Osteoarthritis	___	___
Kidney Disease	___	___	Anemia	___	___	Alcoholism	___	___
Lupus	___	___	Migraines	___	___	Sickle Cell Disease	___	___
Bleeding Tendencies	___	___	Cancer	___	___	Colitis	___	___
Heart Disease	___	___	Diabetes	___	___	Stroke	___	___
Epilepsy	___	___	Goiter	___	___	Stomach Ulcers	___	___
High Blood Pressure	___	___	Lung Disease	___	___	Depression/Anxiety	___	___
Polio	___	___	Nervous System Disorder	___	___	Reflux	___	___
Hepatitis	___	___	Tuberculosis	___	___	Osteoporosis	___	___
						Osteopenia	___	___

Other Medical Conditions: _____

Please list any orthopedic surgeries and dates:

Please list any other surgeries and dates:

Please list all current medications and dosages:

Are you allergic to (Check if you are):

Latex ___ Penicillin ___ Cephalosporin ___ Mycins ___ Sulfa ___ Tetanus ___ Iodine ___ Dyes ___ Aspirin ___
Codeine ___ Morphine ___ Adhesive Tape ___ Arthritis Medicines ___

Foods: (please list): _____

Do you have any body piercing/tattoos ? ___ Yes ___ No If yes, where? _____

Do you currently use tobacco: ___cigarettes ___pipe ___smokeless amount per day: _____ Quit when? _____

Do you drink alcohol: ___beer ___liquor ___wine amount per day: _____ or per week: _____

What is your current occupation? _____

Has anyone in your family had: ___Blood Clots ___Heart Disease ___Cancer ___Diabetes ___Bleeding Problems
___Lung Disease ___High Blood Pressure ___Rheumatologic Disorders

If yes to cancer, what type? _____

Have you recently had any of the following problems or symptoms:

	Yes	No		Yes	No		Yes	No
Chest Pain	___	___	Irregular Heart Beat	___	___	Fainting Spells	___	___
Breathing Difficulties	___	___	Cough	___	___	Cough with Blood	___	___
Numbness or Tingling	___	___	Dizziness	___	___	Headaches or Migraines	___	___
Vision Changes	___	___	Fever or Chills	___	___	Unexpected Weight Loss	___	___
Abdominal Pain	___	___	Nausea or Vomiting	___	___	Diarrhea	___	___
Bloody or Black Tarry Stools	___	___	Loss of Control of Bowels	___	___	Difficulty Starting Urine	___	___
Pain or Burning On Urination	___	___	Blood in Urine	___	___	Loss of Bladder Control	___	___

Patient's Signature: _____ Physician Signature: _____

(I have reviewed this information with the patient)

Date: _____

For Office Use Only: Height _____ Weight _____ BP _____ Pulse _____

Revised 2/26/07