

## Medical History Form

My present problem is: \_\_\_\_\_ First Began? \_\_\_\_\_ Right \_\_\_ Left \_\_\_

If injured, how did it occur? \_\_\_\_\_

Are you left/right hand : \_\_\_\_\_ Ambidextrous \_\_\_\_\_ Age \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Have you had other injuries to the extremity being examined today? \_\_\_ Yes \_\_\_ No When? \_\_\_\_\_  
Describe the injury? \_\_\_\_\_

Allergies to food or medication and type of reaction: \_\_\_\_\_

List all medications you take regularly or occasionally:

Name of medication: \_\_\_\_\_ Dose: \_\_\_\_\_

Do you have any medical problems? If yes, please circle and give a brief description:

- Heart
- Lungs
- Seizures
- Kidneys, Bladder
- Depression
- Bleeding tendencies
- Tendencies for infection
- Exposure to hepatitis
- Exposure to HIV infection (AIDS)
- Exposure to TB infection

Have you had the usual childhood illnesses? \_\_\_ Measles \_\_\_ Mumps \_\_\_ Chicken Pox \_\_\_ None

Have you ever used recreational drugs and if so what drugs? \_\_\_\_\_

Please list all surgeries you have had along with the dates and whether there were complications:

Do you smoke? \_\_\_ Yes \_\_\_ No Packs per day \_\_\_\_\_ for \_\_\_\_\_ years.

Do you use alcohol? \_\_\_ Yes \_\_\_ No \_\_\_ Occasional use Drinks per day \_\_\_\_\_

Caffeine: \_\_\_ Yes \_\_\_ No \_\_\_ Coffee \_\_\_ Tea \_\_\_ Soda Cups/cans per day \_\_\_\_\_

Present employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

## EMPLOYMENT AND ACTIVITY HISTORY

If unemployed or retired, please complete the following. If not applicable, go to the next section:

Retired:  Yes  No Since: \_\_\_\_\_  
On medical leave:  Yes  No Since: \_\_\_\_\_  
Laid off:  Yes  No Since: \_\_\_\_\_  
On total disability:  Yes  No Since: \_\_\_\_\_  
SSD:  Yes  No Next review: \_\_\_\_\_

My present or last job involved:

	OCCASIONALLY	FREQUENTLY	CONTINUOUSLY
Lifting	_____ lbs.	_____ lbs.	_____ lbs.
Bending	_____	_____	_____
Twisting	_____	_____	_____
Sitting	_____ hrs.	_____ hrs.	_____ hrs.
Standing	_____ hrs.	_____ hrs.	_____ hrs.
Walking	_____ hrs.	_____ hrs.	_____ hrs.
Driving	_____ hrs.	_____ hrs.	_____ hrs.

My employer would allow me to return to work with restrictions:  Yes  No

### Activities

What sports related physical activities or hobbies do you engage in:

<input type="checkbox"/> Aerobics	<input type="checkbox"/> Swimming
<input type="checkbox"/> Step aerobics	<input type="checkbox"/> Bicycle riding
<input type="checkbox"/> Walking	<input type="checkbox"/> Karate
<input type="checkbox"/> Golf	<input type="checkbox"/> Volleyball
<input type="checkbox"/> Tennis	<input type="checkbox"/> Basketball
<input type="checkbox"/> Baseball	<input type="checkbox"/> Football
<input type="checkbox"/> Track	<input type="checkbox"/> Weight Training
<input type="checkbox"/> Jogging	<input type="checkbox"/> Other: _____

Have you been limited in these activities:  Yes  No How: \_\_\_\_\_

Other hobbies or activities in which you have participated: \_\_\_\_\_

Do you have an attorney handling this accident or injury?  Yes  No

Attorney's Name: \_\_\_\_\_

Attorney's Address: \_\_\_\_\_