

Tennessee Orthopedics

1616 W. Main Street, Lebanon, TN 37087 (615) 449-0990

Medical History Form

Date _____

Name _____ Prefer to be called _____ Birthdate _____

Male Female Age _____ Height _____ Weight _____ Who is your Family Doctor? _____

What is the **main** problem? _____

What do you think **caused** it? _____

When did it **first start**? _____

What **treatment(s)** have you had for it? _____

What makes it **worse**? _____

What makes it **better**? _____

Having any other symptoms? _____

Have You or a Blood Relative ever had any of the following problems?				Please list ALL medicines you take: (Try to include doses and how often)	
	ME		Family (who?)		
	Yes	No			
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Chest Pains, Angina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Blood Transfusions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Other Blood or Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Fluid in Lungs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Ankle Swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Congestive Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Other Breathing Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Liver Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Intestine Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
HIV / AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Bladder or Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Frequent Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Convulsions or Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Any Other Problems:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

What Medicines are you allergic to?

Please list all Surgeries or Hospitalizations you have had:
(Try to include approximate dates)

Do you smoke cigarettes pipe or cigars?
 Yes No How much? _____

Do you use chewing tobacco or snuff?
 Yes No How much? _____

Do you drink alcohol?
 Yes No How much? _____

Marital Status: _____ Any Children? Yes No If Yes, Number _____ Ages _____

Referring Physician/ PT/ Chiropractor/ School: _____

Address and Phone Number: _____

Are you an Athlete? Yes No If Yes What Sport or Sports? _____ Where? _____

Athletic Trainer's Name: _____ Phone # _____

Coach's Name: _____ Phone # _____

Please List all of the Recreational Activities you have done in the last 3 years: _____

REVIEW OF SYSTEMS

(Please check any problem you currently have or that you have had in the last 6 months)

General

- ___ weight change
- ___ fever or chills
- ___ lumps or masses
- ___ dizziness or fainting
- ___ bleeding

Head and Neck

- ___ headaches
- ___ double vision
- ___ ringing in the ears
- ___ severe hearing loss
- ___ chronic nasal obstruction
- ___ persistent sore gums

Skin

- ___ rash
- ___ sores which won't heal
- ___ scaly dry patches

Heart/Cardiovascular

- ___ chest pain
- ___ skipping heart beats
- ___ ankles swell
- ___ hypertension
- ___ sleep in chair or propped up on pillows to breathe
- ___ shortness of breath

Lungs/Pulmonary

- ___ sit up to breath easier
- ___ have chronic cough
- ___ cough up blood
- ___ wheezing
- ___ having night sweats

Stomach/Intestines

- ___ heartburn
- ___ appetite loss
- ___ black tarry stool
- ___ blood from rectum
- ___ clay colored stools
- ___ jaundice
- ___ difficult swallowing

Urinary Tract/GYN

- ___ frequent urination
- ___ pain with urination
- ___ frequent night urination
- ___ any leakage of urine
- ___ blood in urine
- ___ passed any stones
- ___ uterine bleeding after menopause

Muscle/Joints

- ___ joint/muscle pain
- ___ shoulder pain
- ___ back pain
- ___ knee pain
- ___ hip pain
- ___ foot/ankle pain
- ___ any tingling or numbness if so, where _____
- ___ neck pain

Breast

- ___ lumps, pain
- ___ discharge from nipple

Neurological

- ___ depression
- ___ mental problems
- ___ mental breakdown
- ___ any memory loss
- ___ personality change
- ___ speech changes
- ___ dizzy spells
- ___ any alcohol problems
- ___ any drug problems
- ___ any paralysis
- ___ any shaking
- ___ any strokes