HCA® Physician Services Group

GEORGETOWN ORTHOPEDIC GROUP MEDICAL HISTORY

Patient Name:_____ **Date of Birth**:_____ **Date**:_____

Pharmacy Name/Location:_____

Height:_____ **Weight**:_____ **Home Phone**:_____ **Other Phone**:_____

Primary Care Physician:_____

Reason for Visit:_____

When, where, and how did the problem begin?_____

Is your injury/condition covered by workers comp/employer? ☐ Yes ☐ No If yes, date of injury:_____

Have you received any care elsewhere for this problem? If so, please explain:_____

_____

Have you had any x-rays, MRIs, CT scans, or other diagnostic testing for this problem? If yes, where were these done?

_____

ALLERGIES: Please list any prescription or over-the-counter medication allergies you have and the symptoms you experience:

_____

_____

Are you allergic to latex? ☐ Yes ☐ No **Tape?** ☐ Yes ☐ No

Date of last flu vaccine_____ **Pneumonia vaccine**_____

Date of last colonoscopy_____ Where_____

Diabetic patients – last A1C labs _____ Where_____

Diabetic – last eye exam_____ Where_____

Do you smoke cigarettes? ☐ Yes ☐ No Packs per day?_____

Do you drink alcohol? ☐ Never ☐ Occasional ☐ Moderate ☐ Heavy

Do you exercise? ☐ Yes ☐ No

What is your occupation?_____ **What type of physical activity do you normally perform at work?**_____

Past Medical History:

Do you currently have or have you previously had any trouble with? (circle all that apply)

☐ Cardiovascular Disease ☐ Lung Disease ☐ Diabetes Type I or Type II ☐ Hepatitis ☐ Renal Failure

☐ High Blood Pressure ☐ Blood Clot or DVT ☐ Stomach Ulcers ☐ Anemia ☐ HIV

☐ Heart Failure

Please list any major medical conditions not listed above:_____

_____

Patient Name:_____ **Date of Birth**:_____

Please list any past orthopedic surgical procedures and dates:_____

_____

Family Medical History:

Has anyone in your immediate family had trouble with any of the following? (circle all that apply)

☐ Cardiovascular Disease ☐ Lung Disease ☐ Diabetes Type I or Type II ☐ Renal Failure

☐ High Blood Pressure ☐ Blood Clot or DVT ☐ Stomach Ulcers ☐ Anemia

Female Patients Only:

Are you pregnant? ☐ Yes ☐ No

Age you began menstruating? _____ Date of your most recent menstrual period?_____

Have you experienced menopause or had a hysterectomy? ☐ Yes ☐ No If yes, which and when?_____

Date of last mammogram:_____

Review of Symptoms:

Please check any of the following that apply to you:

☐ Recent weight change
☐ Fatigue/weakness
☐ Fever/chills
☐ Skin rash
☐ Joint stiffness/pain/swelling
☐ Muscle weakness
☐ Swollen legs/feet
☐ Stomach pain/heartburn
☐ Easy bleeding/bruising
☐ Double vision
☐ Headaches
☐ Chest pain
☐ Coughing up blood
☐ Nausea
☐ Vomiting
☐ Blood in urine
☐ Speech difficulties
☐ Excessive thirst

_____ _____

Patient/Guardian Signature **Reviewed By**

_____ _____

Date **MR#**