Name:
Chart:
Date:

Anchorage Fracture & Orthopedic Clinic
The Strength of Experience

Height _____ Weight _____

BP: _____ Pulse: _____ Temp: _____

Medical History Form

Name: _____ DOB _____ AGE _____ Gender: Male/Female

Referring Physician (name/city): _____

Primary Physician (name/city): _____ Send today's note Yes No

Occupation: _____ R or L Handed Work Injury? Yes No Date of Injury _____

Current complaint

1) Chief complaint _____ Right or Left
2) When did the problem start _____ How did it start _____
3) Made better or worse by _____
4) The body part is: Painful yes or no Weak yes or no Stiff yes or no Swollen yes or no Numb yes or no
5) Any imaging (x-rays, MRI, CT) Where and when done _____

Additional info on current injury/problem _____

CURRENT MEDICATIONS--- please list **ALL** medications taken NONE Med list attached

Name of med	Dosage	Name of med	Dosage	Name of med	Dosage

Allergies: ☐ None ☐ Latex ALL ALLERGIES---

Review of Systems: Please note ANY symptoms you have had **within the last SIX MONTHS**

GENERAL			Swollen Ankles	Y	N	Diarrhea	Y	N
Wt loss/gain (unintentional)	Y	N	Shortness of breath	Y	N	**HEMATOLOGICAL**		
Chills	Y	N	Wheezing	Y	N	Blood clots	Y	N
Fever/night sweats	Y	N	Coughing	Y	N	Bleeding disorder	Y	N
SKIN			**GENITOURINARY**			**PSYCH/NEUROLOGICAL**		
Rash/lesions	Y	N	Frequent urination	Y	N	Seizures	Y	N
HEENT			Blood in urine	Y	N	Headaches/Migraines	Y	N
Hay fever	Y	N	**GASTROINTESTINAL**			Dizziness/loss of consciousness	Y	N
Visual problems	Y	N	Indigestion	Y	N	**LYMPHATIC**		
Hearing problems	Y	N	Nausea	Y	N	Swollen/Tender lymph nodes	Y	N
CARDIO/PULMONARY			Vomiting blood	Y	N	**ENDOCRINE**		
Chest pain	Y	N	Black stools	Y	N	Hormonal irregularities	Y	N
Palpitations/Irregular Heartbeat	Y	N	Constipation	Y	N	Blood sugar irregularities	Y	N

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MEDICAL HISTORY: Please circle disease or disorders you have **EVER** been diagnosed with

ADD	DVT (blood clot)	Liver Disease	Stroke
Anemia	Emphysema	MRSA	Thyroid disease
Anxiety	Fractures	Osteoporosis	Tuberculosis
Asthma	Bone_____	Poor circulation	Ulcers
Bipolar	Glaucoma	Pulmonary Embolism	Autoimmune/rheumatologic disorders
Bleeding disorders	Gout	Reflux	TYPE_____
Cancer	Heart attack	Renal failure	Other _____
TYPE _____	High BP	Dialysis_____	_____
Chemo/Radiation	Hepatitis A/B/C	Rheumatic fever	_____
Depression	HIV	Schizophrenia	_____
Diabetes I (insulin)	Kidney Disease	Sleep apnea	**NONE**
Diabetes II	Kidney stones	Staph infection	

PAST SURGICAL HISTORY ---Please list any surgeries that you have had

TYPE	YEAR	TYPE	YEAR	Orthopedic Surgeries	Right/Left	Year

FAMILY HISTORY please indicate whether anyone in your immediate family has a history of the following

Heart disease	High blood pressure	Diabetes	Cancer	Osteoporosis
Bleeding problems	Arthritis	Rheumatoid arthritis	Autoimmune disorder _____	

SOCIAL HISTORY---Marital status Married / Single / Divorced / Separated / Widowed **LIVE WITH** _____

HABITS/RISK FACTORS

1. Tobacco use yes/no Quantity/day _____ Cigarettes/cigars/chew/vapor. Used in past yes/no Started_____ Stopped____
2. Recreational drug use yes/no Type and quantity per day/week _____
3. Have you been treated for addiction or overdose yes/no. Are you on pain contract yes/no With whom _____
4. Do you drink alcohol yes/no Type and quantity per day/week _____
5. Have you had a bone density scan yes/no When/Where _____
6. In the past year have you had a flu vaccine yes/no. Pneumonia vaccine yes/no Are you pregnant yes/no Due _____

Patient/Parent/Guardian Signature: _____ DATE: _____

Health Provider Signature: _____ DATE: _____