Print Form

ASKINS & MILLER ORTHOPAEDICS, P.A. – NEW PATIENT MEDICAL HISTORY

Today's Date _____/_____/_____ Patient Name _____
Last First Middle Initial

Please fill out name exactly as it appears on your Insurance Card – or your insurance company will Deny your claim.

Date Of Birth _____/_____/_____ Family Doctor _____

Today's Health Problem? _____

_____

Where you seen in the Emergency Room? YES ☐ NO ☐
Which Hospital? _____
Is this problem work related? YES ☐ NO ☐
Will Workers Compensation be paying for this injury? _____
Is this injury the result of a Motor Vehicle Accident? _____
Is there a lawsuit involved? _____
Are you disabled? YES ☐ NO ☐
Any recent X-Rays of today's problem? YES ☐ NO ☐
Done where? _____

MEDICAL HISTORY
Check all that apply.
☐ Anemia
☐ Arthritis
☐ Asthma / COPD
☐ Back Disorders
☐ Bleeding Disease(s)
☐ Blood Clots
☐ Cancer-Where? _____
☐ Colitis / Diverticulitis
☐ Diabetes
☐ Broken Bone-what? _____
☐ Gallbladder Disease
☐ Gout
☐ Heart Disease
☐ Heart Attack-when? _____
☐ Hepatitis
☐ Hiatal Hernia
☐ High Blood Pressure
☐ HIV
☐ Kidney Disease / Stones
☐ Stroke
☐ Thyroid Disease

OTHER PROBLEM (ROS)
Check all that apply.
☐ Abnormal Heartbeat
☐ Anesthesia Problems
☐ Calf Cramps When Walking
☐ Chills / Fever
☐ Diarrhea
☐ Eye / Nose / Throat
☐ Hearing Loss
☐ Heart / Chest Pain / Angina
☐ Indigestion / Heartburn

OTHER PROBLEMS (ROS-CONT)
☐ Intestinal Bleeding
☐ Joint Pain / Stiffness
☐ Leg / Skin Ulcers
☐ Mental Illness
☐ Muscle Weakness
☐ Recent Weight Loss
☐ Shortness of Breath

PREVIOUS SURGERIES
Check all that apply.
☐ Appendix
☐ Back / Disc
☐ Bone / Joint-Where?_____
☐ Cancer-
Where?_____
☐ Gallbladder
☐ Heart Bypass / Stent
☐ Hysterectomy
☐ Prostate
☐ Tonsils
☐ Other-List _____

_____

SOCIAL HISTORY
Married ___ Single ___ Divorced ___
Presently living alone? YES ___ NO ___

Do you **SMOKE**? YES __ NO __ NEVER __
How many **packs per day**? _____
When did you **quit**? _____

ALCOHOL? Occasionally/Social ___
Moderate To Heavy ___ Never ___

Marijuana / Cocaine / Heroin? Never ___
Present Problem ___ In Treatment ___
Past Problem-When did you quit? _____

FAMILY HISTORY (Parents or Siblings)
Check all that apply.
☐ AIDS / HIV
☐ Alcoholism
☐ Arthritis
☐ Bleeding Disorders
☐ Cancer
☐ Diabetes
☐ Gout
☐ Heart Disease
☐ Kidney Disease
☐ Mental Illness
☐ Stroke
☐ TB
☐ Other-List _____

AGE _____ **Male** ☐ **Female** ☐

Height _____ **Weight** _____

Pharmacy Name
_____

Pharmacy Phone
_____

CURRENT MEDICATIONS
_____
_____
_____
_____
_____

****SEE ATTACHED MEDICATION LIST** _____

Are you on **Blood Thinning** medication? ____
What? _____

ALLERGIES – List All
_____
_____
_____

Patient's/Guardian's Signature :

_____

OFFICE USE ONLY

Physician's Signature Today's Date

_____ _____
_____ _____
_____ _____
_____ _____

REV 03/14/2007