AGILITY ORTHOPAEDICS

Medical History Form For Andrew M. Wayne, M.D.

Please fill out completely due to this being part of your permanent medical record.

Name: _____ Sex: M/F Date: _____

Date of Birth: _____ Height: _____ Weight: _____ Age: _____

Description of current employment (or most recent job): _____

How long have you been at this job? _____ Who referred you to our office? _____

_____

If not working, date last worked: _____ Is injury work-related? ____ Yes ____ No

If work injury, are you now working Full Duty _____ Light Duty _____ Off Work _____

Describe the injury or disorder and any related symptoms: _____

_____

_____

What date did it begin? _____

How did it occur? _____

_____

_____

Have you ever injured or had problems with this body part before? _____ Yes _____ No

If yes, explain: _____

What treatment has been done for this current condition? (Circle all that apply)

Surgery (specify) _____

Physical Therapy (General start and end dates) _____

Injection(s) (specify) _____

Medications (which ones) _____

Chiropractic (general start and end dates) _____
Massage
Brace/cast

Other _____

Health problems (not surgeries):

_____

_____

Past Surgical History: (Please list year of surgery)

_____

_____

Please list any diagnostic studies you have had for this condition (date & place)
X-rays: _____

MRI: _____

Cat scan: _____

EMG/Nerve conduction study: _____

Blood test (s): _____

Other: _____

List Allergies to medication (s) None or list: _____ Latex Y ____ N ____

_____ Iodine Y ____ N ____

Please list all Current Medications: (include doses if you know)
1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

Social History: Do you live with someone that can help you? Y _____ N_____

Marital Status: Married / Single / Divorced / Widowed

Alcohol Y____ N ____ Occasional ____ Moderate ____ Heavy ____

History of alcohol abuse Y____ N ____ History of Drug abuse ____Y ____N

Tobacco Y ____N ____ Years used ____ Packs per day ____ Recreational drug use Y____ N ____

Do you use a cane, walker or wheelchair? Y____ N ____ (Circle which one if it applies.)

Family Medical History: (Circle all that apply)

Stroke	Diabetes	Seizures	Cancer
Heart disease	Arthritis	Mental illness	Bleeding disorder
High blood pressure	Gout	Kidney disease	Alcoholism

Other Illness _____

_____

Review of Systems: Please check all that apply:

General

___Weight Change
(__Gain ___Loss)
___ Fever
___ Chills
___ Night Sweats
___ Fainting
___ Bleeding Disorder
___ Lumps (Location)
___ Dizziness
___ Itching
___ Rash
___ Diabetes Mellitus
___ Thyroid Problems
___ Cancer (Specify)
_____

Ear – Nose – Throat – Eye

___ Visual Change
___ Hearing Change
___ Ringing in Ears
___ Dentures
___ Bleeding Gums
___ Hoarseness
___ Vertigo

Musculoskeletal

___ Neck Pain
___ Mid Back Pain
___ Low Back Pain
___ Joint Pain
___ Joint Swelling
___ Osteoporosis
___ Broken Bone (Specify)
_____

Cardiovascular

___ Heart Disease
___ Chest Pain
___ High Blood Pressure
___ Mitral Valve Prolapse
___ Vein Problem
___ Swelling in legs
___ Blood Clot
___ High Cholesterol
___ Rheumatic Fever
___ Pacemaker
___ Rapid or Irreg. Heartbeat

Respiratory

___ Cough (dry, productive)
___ Tuberculosis
___ Sinus Congestion
___ Pneumonia
___ Shortness of Breath
___ Asthma
___ Chronic Lung Disease

Genitourinary

___ Urinary tract infection
___ Incontinence
Circle (bowel/bladder)
___ Venereal Disease
___ Menopause
___ Frequent Urination
___ Kidney Stone
___ Kidney Disease

Breast

___ Lumps
___ Pain
___ Discharge

Neurologic

___ Seizures (Most Recent)
_____
___ Headache
___ Numbness
Circle Arms / Legs
___ Weakness
Circle Arms / Legs
___ Concussion
___ Memory Loss
___ Pain shooting down arms
Circle Right Left
___ Pain shooting down legs
Circle Right Left

Psychiatric

___ Depression
___ Anxiety
___ Bipolar Disorder
___ Schizophrenia

Gastrointestinal

___ Diff. Swallowing
___ Nausea
___ Vomiting
___ Jaundice
___ Hepatitis
___ Ulcer Disease
___ Diarrhea
___ Constipation
___ Acid Reflux
___ Liver Disease

Other not listed above: _____

I hereby acknowledge by signing this sheet that all of the information is complete and accurate.

Signature _____ Date _____