MERCER-BUCKS ORTHOPAEDICS PC
MEDICAL HISTORY FORM

Name : _____ **Date:** _____

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

Primary Care Physician: _____ Cardiologist/Specialist: _____

How did you hear about us? ☐ Friend/Family ☐ Advertisement ☐ Referral from medical facility/ER ☐ Website ☐ Other

X-ray/MRI taken? ☐ Yes ☐ No If yes, what facility? _____

Primary body part to be seen (For example: Left Knee): _____

Other body part to be seen: _____

		Date	***How Injury Occurred?***
Is this problem due to an injury?	☐ No ☐ Yes		
Onset:			
Is this injury work related?	☐ No ☐ Yes		
Is injury related to an Auto Accident?	☐ No ☐ Yes		
Have you had a fall in the last year?	☐ No ☐ Yes	**Did the fall result in an injury?** ☐ No ☐ Yes	

PAST MEDICAL HISTORY: *(Select all current and previous illnesses)*

- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Blood Clot
- ☐ Colitis
- ☐ COPD/Lung Disease
- ☐ Depression
- ☐ Fibromyalgia
- ☐ GERD
- ☐ Glaucoma
- ☐ Gout
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver-Disorder
- ☐ Lyme's Disease
- ☐ Neuropathy
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Paget's Disease
- ☐ Seizures
- ☐ Shingles
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Ulcers
- ☐ Vascular Disease
- ☐ None

CANCER ☐ **Yes** ☐ **No**

Select Type of Cancer:

- ☐ **Bladder**
- ☐ **Blood**
- ☐ **Bone**
- ☐ **Brain**
- ☐ **Breast**
- ☐ **Cervical**
- ☐ **Colon**
- ☐ **Kidney**
- ☐ **Liver**
- ☐ **Lung**
- ☐ **Melanoma**
- ☐ **Pancreas**
- ☐ **Prostate**
- ☐ **Stomach**
- ☐ **Testicular**
- ☐ **Throat**
- ☐ **Thyroid**
- ☐ **Uterine**
- ☐ **Other**

If Other, Please mention here : _____

Heart Disease: ☐ **Yes** ☐ **No** **Pacemaker:** ☐ **Yes** ☐ **No**

Arthritis: ☐ **Yes** ☐ **No** **Type:** _____

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Hepatitis ☐ Yes ☐ No If Yes, Select the Type? ☐ Type A ☐ Type B ☐ Type C

Diabetic ☐ Yes ☐ No If Yes, Select the Type? ☐ Type I ☐ Type II

Sleep Apnea? ☐ Yes ☐ No **C-Pap Use?** ☐ **Yes** ☐ **No**

Had Bone Density test (Dexa-Scan)? ☐ **Yes** ☐ **No** If Yes, mention the Year :_____

Any Other Medical Conditions :_____

Pain Level: (0-10) 0 = No pain, 10 = Worst possible pain:_____

ALLERGIES

Do you have any Allergies? (Please be sure to include any allergies to Medications, Antibiotics, Latex, Iodine, Shellfish, Seafood or Metal) ☐ **Yes** ☐ **No**

List of Allergies: _____

MEDICATIONS:

Do you take any medications or vitamins regularly? ☐ **Yes** ☐ **No**

PAST SURGICAL HISTORY

Do you have any past surgeries? ☐ Yes ☐ No

If yes, Please select all that are applicable from the list below:

- ☐ **Appendectomy**
- ☐ **Back Surgery**
- ☐ **Carpal Tunnel**
- ☐ **Cataract Surgery**
- ☐ **Cesarean Section**
- ☐ **Gallbladder Surgery**
- ☐ **Hip Replacement**
- ☐ **Hemorrhoidectomy**
- ☐ **Heart Surgery**
- ☐ **Hysterectomy**
- ☐ **Hernia Repair**
- ☐ **Knee Replacement**
- ☐ **Knee Scope (meniscus)**
- ☐ **Prostate Surgery**
- ☐ **Rotator Cuff Repair**
- ☐ **Thyroid Surgery**
- ☐ **Tonsillectomy/Adenoidectomy**
- ☐ **Surgery related to Cancer**
- ☐ **Other**

Type of Other Surgery:_____

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FAMILY HISTORY

	Father	Mother	Brother	Sister	Son	Daughter	None
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐
Heart Diseases	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐
Blood Clots	☐	☐	☐	☐	☐	☐	☐
Arthritis (Osteo/bone)	☐	☐	☐	☐	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐

Do you have any other family member with a major illness to report? ☐ Yes ☐ No If Yes, Explain: _____

SOCIAL HISTORY

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated

Use of Alcohol ☐ Never ☐ Rarely ☐ Moderate ☐ Daily

Use of Tobacco ☐ Never ☐ Previously but quit ☐ Current packs/day: _____

Have you smoked in the last two months? ☐ Yes ☐ No

Are you right or left handed? ☐ Left ☐ Right ☐ Ambidextrous

Living Situation: ☐ Alone ☐ with Friends ☐ with Spouse ☐ with Family

What is your employment status? ☐ Working full time ☐ Working full time ☐ Unemployed ☐ Retired from work

What is the type of work you do? _____

Are there religious/cultural needs related to your care? ☐ Yes ☐ No

Please explain: _____

Do you use any recreational drugs? ☐ Yes ☐ No Treated for Substance Abuse? ☐ Yes ☐ No

Possibility of Pregnancy? ☐ Yes ☐ No

SYSTEMS REVIEW *(Did you have any of the following symptoms within the past 6 months?)*

Good general health lately? ☐ Yes ☐ No

Constitutional Symptoms
- ☐ Fatigue
- ☐ Fever
- ☐ Recent weight change
- ☐ None

Hematologic/Lymphatic
- ☐ Past blood transfusion
- ☐ None

Gastrointestinal
- ☐ Abdominal pain
- ☐ Heartburn
- ☐ Loss of appetite
- ☐ Nausea
- ☐ Vomiting
- ☐ None

Neurological
- ☐ Dizziness
- ☐ Light-headedness
- ☐ Paralysis
- ☐ Tremors
- ☐ None

Psychiatric
- ☐ Confusion
- ☐ Insomnia
- ☐ Memory loss
- ☐ Nervousness
- ☐ None

Musculoskeletal
- ☐ History of fractures
- ☐ None