Connecticut Center for Orthopedic Surgery, LLC Medical History

Name _____ Age _____ Today's Date _____

Who may we thank for referring you? _____Who is your medical doctor? _____

When did the problem start to bother you? _____ Date: if this is an injury _____

Where did the injury occur? _____ In which town did the injury occur? _____

Which side are you having evaluated today? **Right** **Left** **Both**

Describe the injury or nature of the problem and symptoms.

_____

_____

_____

When do you have this problem? _____
What makes it better? _____
What makes it worse? _____

Have you ever had prior problems or injuries with this part of your body? If yes, please explain. _____

_____

Is this a work related condition? Yes No Unsure

Are your ❑ right-handed ❑ left-handed? Height_____ Weight _____

P _____ R _____ BP _____

Past Medical History *Please answer **all** questions by checking **Yes** or **No.***

General	Yes	No
High Blood Pressure	❑	❑
High cholesterol	❑	❑
Gout	❑	❑
Psoriasis	❑	❑
Blood clots	❑	❑
Phlebitis	❑	❑
HIV Positive / AIDS	❑	❑
Drug abuse / addiction	❑	❑
Alcoholism	❑	❑

Eyes		
Cataracts	❑	❑
Glaucoma	❑	❑
Lens implants	❑	❑

Head and Neck		
Deafness	❑	❑
Sinusitis	❑	❑
Sleep apnea	❑	❑

Skin / Breast		
Breast masses	❑	❑
Breast cancer	❑	❑
Skin lesions	❑	❑
Skin ulcers	❑	❑
Skin Cancer	❑	❑

Endocrine		
Diabetes ____# years	❑	❑
Thyroid problems	❑	❑

Heart	Yes	No
Atrial Fibrillation	❑	❑
Heart attack ____ year	❑	❑
Congestive heart failure	❑	❑
Mitral valve prolapse	❑	❑
Murmur	❑	❑
Other heart condition	❑	❑

Lungs		
Asthma	❑	❑
COPD	❑	❑
Emphysema	❑	❑
Cancer	❑	❑
Pulmonary embolus	❑	❑

Gastrointestinal		
Hepatitis: A, B, C	❑	❑
Cirrhosis	❑	❑
GERD / Reflux	❑	❑
Ulcers	❑	❑
Hiatal hernia	❑	❑
Colon problems	❑	❑
Polyps	❑	❑
Cancer	❑	❑

GU System		
Urinary hesitancy	❑	❑
Urinary incontinence	❑	❑
Kidney failure	❑	❑
Prostate problems	❑	❑
Bladder problems	❑	❑
Cancer	❑	❑

Women	Yes	No
# Pregnancies_____	❑	❑
# Children_____	❑	❑
Menopause	❑	❑

Musculoskeletal		
Osteoporosis	❑	❑
Joint replacement	❑	❑
Bone infection	❑	❑
Osteoarthritis (wear & tear)	❑	❑
Rheumatoid arthritis	❑	❑
Systemic Lupus	❑	❑
Previous fractures	❑	❑
Fibromyalgia / Fibrositis	❑	❑
History of Lyme disease	❑	❑
Other joint disease	❑	❑

Neuro		
Stroke	❑	❑
Seizures	❑	❑
Loss of balance	❑	❑
Loss of memory	❑	❑
Depression / Anxiety	❑	❑
Sleep disturbances	❑	❑
Psychiatric illness	❑	❑

(Specify)

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Review of Systems *Please answer **all** questions by checking **Yes** or **No** for all that apply in the past **6 months.***

General	Yes	No
Good general health lately	❑	❑
Unexplained weight loss	❑	❑
Loss of appetite	❑	❑
Night sweats	❑	❑
Fatigue	❑	❑

Hematologic / Lymphatic		
Transfusion reaction	❑	❑
Easy bruising	❑	❑
Slow to heal after cuts	❑	❑

Eyes		
Corrective lenses	❑	❑
Changes in vision	❑	❑
Eye pain	❑	❑
Redness	❑	❑

ENT		
Headaches	❑	❑
Hearing loss	❑	❑
Ringing in ears	❑	❑
Dizziness	❑	❑
Hoarse voice	❑	❑
Swollen glands	❑	❑
Difficulty swallowing	❑	❑

Cardiovascular		
Chest pain	❑	❑
Difficulty breathing while sleeping	❑	❑
Shortness of breath with exertion	❑	❑
Sudden heart beat changes	❑	❑
Fainting episodes	❑	❑

Pulmonary	Yes	No
Cough	❑	❑
Wheezing	❑	❑
Shortness of breath	❑	❑
Spitting up blood	❑	❑

Gastrointestinal		
Nausea	❑	❑
Vomiting	❑	❑
Diarrhea	❑	❑
Constipation	❑	❑
Stomach pain	❑	❑
Blood in stool	❑	❑
Difficulty swallowing	❑	❑

Endocrine		
Excessive thirst	❑	❑
Excessive urination	❑	❑
Increased appetite	❑	❑
Increase sweating	❑	❑

GU	Yes	No
Blood in urine	❑	❑
Painful urination	❑	❑
Frequent urination	❑	❑
Urgency	❑	❑
Changes in menstruation	❑	❑

Neuro & Psych		
Change in sense of smell	❑	❑
Change in sense of taste	❑	❑
Dizziness	❑	❑
Weakness	❑	❑
Tremors	❑	❑
Numbness / Tingling	❑	❑
Nervous / Anxiety	❑	❑
Depression	❑	❑

Skin		
Skin changes	❑	❑
Rash / Redness	❑	❑

Musculoskeletal *(Other than the reason you are here today)*		
Joint pain	❑	❑
Joint stiffness	❑	❑
Joint swelling	❑	❑
Difficulty walking	❑	❑

Please answer all questions.

Past Surgical History ❑ **I have never had surgery**

Surgery	Year	Surgery	Year
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies ❑ **I have no medication allergies**

Are you allergic to **penicillin**? No Yes If yes, reaction _____
Are you allergic to **latex**? No Yes If yes, reaction _____

Medication allergies	Reaction	Medication allergies	Reaction
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Current Medications (Include name and dose of medications) ❑ **I take no medications.**

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Over-the-counter herbal supplements, vitamins, medications (Include name and dose) ❑ **I take none.**

_____ _____ _____
_____ _____ _____
_____ _____

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*Please answer **all** questions.*

Can you take anti-inflammatory medications like aspirin, Motrin (ibuprofen), Aleve (naproxen)? Yes No Unsure

Social History

Married Civil Union Single Widowed Divorced Separated Children: Yes No Ages: _____

Employer _____ Occupation _____ How long? _____

Tobacco: Smoking No Yes: ½ 1 2 packs per day for _____ years? If you stopped, how many years ago did you quit? _____

Do you ever drink **alcohol**? No Rarely Socially Moderately Daily Amount: _____

Drug use: Marijuana Cocaine Heroine Methamphetamine Other illicit drugs_____

Do you take **prescription pain medication** (Percocet, Vicodin, Oxycontin) on a regular basis? Yes No

Education: Last grade completed____ High school graduate GED Some college: _____ years College Graduate Advanced degree _____

Family Medical History Indicate any medical conditions that may affect or have affected these members of your family.

Mother _____ Children _____ Grandparents _____
Father_____ _____ _____
Siblings_____ _____ _____
_____ _____ _____

Patient Signature_____ Today's Date_____

I have reviewed this form. All pertinent positives and negatives in the patient's medical history and review of systems are noncontributory, unless otherwise indicated, as noted from the patient questionnaire.

_____MD Date_____ _____MD Date_____
James T Mazzara, MD James T Mazzara, MD