Capital City Orthopaedics Medical History

Michael W. Burris, M.D. Omar H. Akhtar, M.D.

Name: _____ Date of Birth: _____

Referring Physician _____ Primary Physician _____

How did you hear about our office? _____

Chief Complaint

What problem are you here for today? _____

What is the date of injury or symptom onset date? _____

How did the injury occur? _____

Where did the injury occur? _____

Is this work related? ☐ If yes, did you file a Workers' Compensation claim? ☐

Have you had any physical therapy? _____

What medications have you taken for pain? _____

Have you had any injections performed? _____

Have you had: X-rays ☐ MRI ☐ CT scan ☐ EMG ☐ other _____

Where were the images/studies done? _____

Medical History

Current medical issues: (e.g. diabetes, high blood pressure, pregnancy):

_____

_____

_____

Surgical History:

_____

_____

_____

Family History:

Do you have a family history of: Diabetes ☐ Rheumatoid Arthritis ☐ Heart Disease ☐

Other _____

Capital City Orthopaedics Medical History

Michael W. Burris, M.D. Omar H. Akhtar, M.D.

Social History:

What is your occupation? _____

Do you drink alcohol?

No? ☐ Yes? ☐ If yes, drinks per day? _____

Do you exercise?

No? ☐ Yes? ☐

Are you a Current Smoker? No? ☐ Yes? ☐

Every Day? ☐ Some Days? ☐ Former Smoker? ☐ Never Smoker? ☐

Review of Systems

	Yes	No		Yes	No
Fever/Chills	☐	☐	Open wounds	☐	☐
Difficulty sleeping due to pain	☐	☐	Rash on affected area	☐	☐
Weight Gain	☐	☐	Seizures	☐	☐
Weight Loss	☐	☐	Loss of Balance	☐	☐
Joint Pain	☐	☐	Numbness/Tingling	☐	☐
Joint Swelling or Stiffness	☐	☐	Stroke	☐	☐
Asthma	☐	☐	Diabetes	☐	☐
Chest Pain	☐	☐	Thyroid Disorder	☐	☐
Shortness of Breath	☐	☐	Blood Clots	☐	☐
High Blood Pressure	☐	☐	Bleeding Disorder	☐	☐
Heart Failure	☐	☐	Reaction to Anesthesia	☐	☐
Ulcers	☐	☐	Kidney Failure	☐	☐
Hepatitis	☐	☐	Dialysis	☐	☐
Heartburn	☐	☐			

Height:_____ **Weight:**_____

Capital City Orthopaedics Medical History

Michael W. Burris, M.D. Omar H. Akhtar, M.D.

Current Medications with Dosage: None: ☐ **Established Patients: No change from previous visit** ☐

_____ _____

_____ _____

_____ _____

_____ _____

_ _____ _____

Drug Allergies No Known Drug Allergies: ☐ **Established Patients: No change from previous visit** ☐

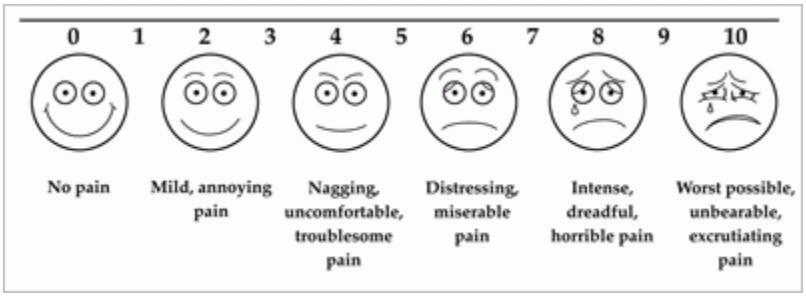
_____

_____

_____

_____

Please rate your pain by marking the corresponding number:



_____ _____

Patient's Signature Date