

**Greater Hartford  
Orthopedic Group, P.C.**

**PATIENT MEDICAL HISTORY**

**DATE:** \_\_\_\_\_

PLEASE PRINT & FILL OUT COMPLETELY

PATIENT'S NAME:	BIRTH DATE	AGE
PRIMARY CARE PHYSICIAN:	HEIGHT:	WEIGHT: PREGNANT? YES NO
REFERRING PHYSICIAN:	SMOKER: YES NO	# PACKS/DAY:
	ALCOHOL: YES NO	HOW MUCH?
	DRUG USE: YES NO	EXPLAIN:
REASON FOR VISIT:		
DATE OF ONSET/INJURY:	JOB RELATED?	AUTO ACCIDENT?
WAS THERE AN INJURY? YES NO EXPLAIN:		
WHAT MAKES THE PAIN/PROBLEM BETTER OR WORSE?		
PRIOR TREATMENT: (Surgery, Braces, Physical Therapy, Injections, Medications)		

**MEDICAL HISTORY**

(Circle all that apply - provide explanation in space provided below)

DIABETES	HIGH BLOOD PRESSURE	HEART PROBLEMS	BLEEDING PROBLEMS	ULCERS
LIST <u>ALL</u> CURRENT MEDICAL CONDITIONS:				

**REVIEW OF SYSTEMS/PROBLEMS**

(Circle all that apply - provide explanation in space provided below)

HEPATITIS / HIV	SHORTNESS OF BREATH	EYE / VISION	SKIN / RASH
STEROIDS USE?	CHEST PAIN	STOMACH/INTESTINE	VARICOSE VEINS
HEADACHES / DIZZINESS	WHEEZING / COUGHING	SWOLLEN GLANDS	WEIGHT LOSS / GAIN
FEVER / CHILLS	EARS / NOSE / THROAT	URINARY PROBLEMS	PSYCHIATRIC

**EXPLAIN CONDITIONS/SYMPTOMS FROM ABOVE:**

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**LIST ALL PRIOR SURGERIES:**

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**LIST ALL CURRENT MEDICATIONS - INCLUDE DIETARY SUPPLEMENTS, VITAMINS AND/OR DIET PILLS:**

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**LIST ALL ALLERGIES:**

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**DO YOU HAVE A LATEX SENSITIVITY? YES NO**