

Carrollton Orthopaedic Clinic, P.C.  
Medical History Form

Today's Date: \_\_\_\_\_

Patient \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Medical Doctor: \_\_\_\_\_ Referred By: \_\_\_\_\_

*Present Problems:*

Chief complaint/what hurts? \_\_\_\_\_

Did you ever have an injury?  yes  no If so, when? \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

*Have you ever had/have problems with any of the following?*

- |   |  |  |                                       |
|---|--|--|---------------------------------------|
| <input type="checkbox"/> heart attack   | <input type="checkbox"/> heart disease | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> liver/jaundice | <input type="checkbox"/> stroke        | <input type="checkbox"/> lung disease        | <input type="checkbox"/> seizures     |
| <input type="checkbox"/> asthma         | <input type="checkbox"/> anesthesia    | <input type="checkbox"/> stomach ulcers      | <input type="checkbox"/> kidneys      |
| <input type="checkbox"/> head injury    | <input type="checkbox"/> migraines     | <input type="checkbox"/> bleeding disorder   | <input type="checkbox"/> diabetes     |
| <input type="checkbox"/> cancer         |  |  |                                       |

Treatment: \_\_\_\_\_ What: \_\_\_\_\_

*Previous Surgeries:*

\_\_\_\_\_  
\_\_\_\_\_

<i>Medications</i>	<i>Dosage</i>	<i>Conditions for which medication prescribed</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any allergies?  yes  no To medications? \_\_\_\_\_

*Social History*

- Marital Status:  Single  Married  Divorced  Widowed  
Children:  Sons \_\_\_\_\_  Daughters \_\_\_\_\_  None  
Living Situation:  alone  with spouse/family  with friends  
Drink Alcohol:  frequently  occasionally  never

Are you  right  left-handed?

Sports activities you enjoy? \_\_\_\_\_

Type of work that you do: \_\_\_\_\_

*Family History*

	<i>Age</i>	<i>Diseases</i>	<i>If deceased, cause of death</i>
Father _____	_____	_____	_____
Mother _____	_____	_____	_____
Brother(s) _____	_____	_____	_____
Sister(s) _____	_____	_____	_____
_____	_____	_____	_____

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date

I give permission to the Carrollton Orthopaedic Clinic, P.C. and/or West Georgia Rheumatology to disclose any information regarding my treatment to the following people in the event that they may need information about me over the telephone.

Name(s)

Parent(s) \_\_\_\_\_

Child(ren) \_\_\_\_\_

Friend(s) \_\_\_\_\_

Other \_\_\_\_\_

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To be completed by Carrollton Orthopaedic Clinic, P.C.:

After a good-faith attempt to obtain the acknowledgement of the receipt, the patient or representative refused or was unable to sign the Privacy Notice for the following reason(s):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Carrollton Orthopaedic Clinic Representative

\_\_\_\_\_  
Date