

**Connecticut Center for Orthopedic Surgery, LLC**

**Medical History**

Name \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_ Who is your medical doctor? \_\_\_\_\_

Date of injury \_\_\_\_\_ When did the problem start to bother you? \_\_\_\_\_

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

Describe the injury or nature of the problem and symptoms.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Where did the injury occur? \_\_\_\_\_ In which town did the injury occur? \_\_\_\_\_

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 you    right-handed     left-handed?    Height \_\_\_\_\_    Weight \_\_\_\_\_

***Past medical History and Review of Systems*** (Please circle all that apply)

**General**

Diabetes \_\_\_\_ # years  
High Blood Pressure  
Gout  
Fevers  
Weight loss  
Weight gain  
HIV Positive / AIDS  
Drug addiction  
Alcoholism  
Psoriasis

**Eyes**

Cataracts  
Glaucoma  
Lens implants

**Head and Neck**

Deafness  
Sinusitis  
Hoarseness

**Skin / Breast**

Breast masses  
Breast cancer  
Skin lesions / ulcers

**Endocrine**

Thyroid problems  
Anemia

**Heart**

Chest pain  
Palpitations  
Irregular heart rhythm  
Heart attack \_\_\_\_ year  
Heart failure  
Mitral valve prolapse  
Murmur

**Lungs**

Asthma  
COPD  
Wheezing  
Emphysema  
Cough  
Pulmonary embolus

**Gastrointestinal**

Hepatitis: A, B, C  
Cirrhosis  
Jaundice  
GERD / Reflux  
Hiatal hernia  
Colon problems  
Diarrhea  
Constipation  
Polyps  
Cancer

**Women**

# Pregnancies \_\_\_\_\_  
# Children \_\_\_\_\_  
Menopause

**GU System**

Urinary hesitancy  
Urinary incontinence  
Prostate problems  
Bladder problems

**Musculoskeletal**

Osteoporosis  
Joint replacement  
Bone infection  
Rheumatoid arthritis  
Previous fractures  
Fibromyalgia / Fibrositis  
History of Lyme disease  
Joint swelling  
Joint stiffness

**Neuro**

Stroke  
Numbness / tingling  
Seizures  
Loss of balance  
Loss of memory  
Depression  
Sleep disturbances  
Psychiatric illness

This form is continued on the next page.



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

<u>Surgery</u>	<u>Year</u>	<u>Surgery</u>	<u>Year</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**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 \_\_\_\_\_

<u>Medication allergies</u>	<u>Reaction</u>	<u>Medication allergies</u>	<u>Reaction</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**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.

_____	_____	_____
_____	_____	_____
_____	_____	_____

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

**Social History**

Married Single Widowed Divorced Separated Children: Yes No Ages:

Employment \_\_\_\_\_ Position \_\_\_\_\_ How long? \_\_\_\_\_

Do you or did you ever smoke? No Yes: 1/2 1 2 packs per day for \_\_\_\_\_ years? Stopped smoking how many years ago? \_\_\_\_\_

Do you ever drink alcohol? No Rarely Socially Moderately Daily Amount: \_\_\_\_\_

Educational Background: Last grade completed \_\_\_\_\_ High school graduate GED Some college: \_\_\_\_\_ years  
College Graduate Advanced degree \_\_\_\_\_

**Family Medical History** Indicate any medical conditions that me affect or have affected these members of you family.

Mother \_\_\_\_\_ Children \_\_\_\_\_ Grandparents \_\_\_\_\_

Father \_\_\_\_\_

Siblings \_\_\_\_\_

\_\_\_\_\_

Patient Signature \_\_\_\_\_ 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 \_\_\_\_\_ James T Mazzara, MD \_\_\_\_\_ MD Date \_\_\_\_\_

James T Mazzara, MD

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