

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 you 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 | <input type="checkbox"/> | <input type="checkbox"/> |
| High cholesterol | <input type="checkbox"/> | <input type="checkbox"/> |
| Gout | <input type="checkbox"/> | <input type="checkbox"/> |
| Psoriasis | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood clots | <input type="checkbox"/> | <input type="checkbox"/> |
| Phlebitis | <input type="checkbox"/> | <input type="checkbox"/> |
| HIV Positive / AIDS | <input type="checkbox"/> | <input type="checkbox"/> |
| Drug abuse / addiction | <input type="checkbox"/> | <input type="checkbox"/> |
| Alcoholism | <input type="checkbox"/> | <input type="checkbox"/> |

Eyes

- | | | |
|---------------|--------------------------|--------------------------|
| Cataracts | <input type="checkbox"/> | <input type="checkbox"/> |
| Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> |
| Lens implants | <input type="checkbox"/> | <input type="checkbox"/> |

Head and Neck

- | | | |
|-------------|--------------------------|--------------------------|
| Deafness | <input type="checkbox"/> | <input type="checkbox"/> |
| Sinusitis | <input type="checkbox"/> | <input type="checkbox"/> |
| Sleep apnea | <input type="checkbox"/> | <input type="checkbox"/> |

Skin / Breast

- | | | |
|---------------|--------------------------|--------------------------|
| Breast masses | <input type="checkbox"/> | <input type="checkbox"/> |
| Breast cancer | <input type="checkbox"/> | <input type="checkbox"/> |
| Skin lesions | <input type="checkbox"/> | <input type="checkbox"/> |
| Skin ulcers | <input type="checkbox"/> | <input type="checkbox"/> |
| Skin Cancer | <input type="checkbox"/> | <input type="checkbox"/> |

Endocrine

- | | | |
|-----------------------|--------------------------|--------------------------|
| Diabetes ____ # years | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid problems | <input type="checkbox"/> | <input type="checkbox"/> |

Heart

- | | Yes | No |
|--------------------------|--------------------------|--------------------------|
| Atrial Fibrillation | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart attack ____ year | <input type="checkbox"/> | <input type="checkbox"/> |
| Congestive heart failure | <input type="checkbox"/> | <input type="checkbox"/> |
| Mitral valve prolapse | <input type="checkbox"/> | <input type="checkbox"/> |
| Murmur | <input type="checkbox"/> | <input type="checkbox"/> |
| Other heart condition | <input type="checkbox"/> | <input type="checkbox"/> |

Lungs

- | | | |
|-------------------|--------------------------|--------------------------|
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> |
| COPD | <input type="checkbox"/> | <input type="checkbox"/> |
| Emphysema | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> |
| Pulmonary embolus | <input type="checkbox"/> | <input type="checkbox"/> |

Gastrointestinal

- | | | |
|--------------------|--------------------------|--------------------------|
| Hepatitis: A, B, C | <input type="checkbox"/> | <input type="checkbox"/> |
| Cirrhosis | <input type="checkbox"/> | <input type="checkbox"/> |
| GERD / Reflux | <input type="checkbox"/> | <input type="checkbox"/> |
| Ulcers | <input type="checkbox"/> | <input type="checkbox"/> |
| Hiatal hernia | <input type="checkbox"/> | <input type="checkbox"/> |
| Colon problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Polyps | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> |

GU System

- | | | |
|----------------------|--------------------------|--------------------------|
| Urinary hesitancy | <input type="checkbox"/> | <input type="checkbox"/> |
| Urinary incontinence | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney failure | <input type="checkbox"/> | <input type="checkbox"/> |
| Prostate problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Bladder problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> |

Women

- | | Yes | No |
|---------------------|--------------------------|--------------------------|
| # Pregnancies _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| # Children _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Menopause | <input type="checkbox"/> | <input type="checkbox"/> |

Musculoskeletal

- | | | |
|------------------------------|--------------------------|--------------------------|
| Osteoporosis | <input type="checkbox"/> | <input type="checkbox"/> |
| Joint replacement | <input type="checkbox"/> | <input type="checkbox"/> |
| Bone infection | <input type="checkbox"/> | <input type="checkbox"/> |
| Osteoarthritis (wear & tear) | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatoid arthritis | <input type="checkbox"/> | <input type="checkbox"/> |
| Systemic Lupus | <input type="checkbox"/> | <input type="checkbox"/> |
| Previous fractures | <input type="checkbox"/> | <input type="checkbox"/> |
| Fibromyalgia / Fibrositis | <input type="checkbox"/> | <input type="checkbox"/> |
| History of Lyme disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Other joint disease | <input type="checkbox"/> | <input type="checkbox"/> |

Neuro

- | | | |
|-------------------------------|--------------------------|--------------------------|
| Stroke | <input type="checkbox"/> | <input type="checkbox"/> |
| Seizures | <input type="checkbox"/> | <input type="checkbox"/> |
| Loss of balance | <input type="checkbox"/> | <input type="checkbox"/> |
| Loss of memory | <input type="checkbox"/> | <input type="checkbox"/> |
| Depression / Anxiety | <input type="checkbox"/> | <input type="checkbox"/> |
| Sleep disturbances | <input type="checkbox"/> | <input type="checkbox"/> |
| Psychiatric illness (Specify) | <input type="checkbox"/> | <input type="checkbox"/> |

Continue on next page

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

General	Yes No	Cardiovascular		GU	Yes No
Good general health lately	<input type="checkbox"/> <input type="checkbox"/>	Chest pain	<input type="checkbox"/> <input type="checkbox"/>	Blood in urine	<input type="checkbox"/> <input type="checkbox"/>
Unexplained weight loss	<input type="checkbox"/> <input type="checkbox"/>	Difficulty breathing while sleeping	<input type="checkbox"/> <input type="checkbox"/>	Painful urination	<input type="checkbox"/> <input type="checkbox"/>
Loss of appetite	<input type="checkbox"/> <input type="checkbox"/>	Shortness of breath with exertion	<input type="checkbox"/> <input type="checkbox"/>	Frequent urination	<input type="checkbox"/> <input type="checkbox"/>
Night sweats	<input type="checkbox"/> <input type="checkbox"/>	Sudden heart beat changes	<input type="checkbox"/> <input type="checkbox"/>	Urgency	<input type="checkbox"/> <input type="checkbox"/>
Fatigue	<input type="checkbox"/> <input type="checkbox"/>	Fainting episodes	<input type="checkbox"/> <input type="checkbox"/>	Changes in menstruation	<input type="checkbox"/> <input type="checkbox"/>
Hematologic / Lymphatic		Pulmonary	Yes No	Neuro & Psych	
Transfusion reaction	<input type="checkbox"/> <input type="checkbox"/>	Cough	<input type="checkbox"/> <input type="checkbox"/>	Change in sense of smell	<input type="checkbox"/> <input type="checkbox"/>
Easy bruising	<input type="checkbox"/> <input type="checkbox"/>	Wheezing	<input type="checkbox"/> <input type="checkbox"/>	Change in sense of taste	<input type="checkbox"/> <input type="checkbox"/>
Slow to heal after cuts	<input type="checkbox"/> <input type="checkbox"/>	Shortness of breath	<input type="checkbox"/> <input type="checkbox"/>	Dizziness	<input type="checkbox"/> <input type="checkbox"/>
		Spitting up blood	<input type="checkbox"/> <input type="checkbox"/>	Weakness	<input type="checkbox"/> <input type="checkbox"/>
Eyes		Gastrointestinal		Tremors	<input type="checkbox"/> <input type="checkbox"/>
Corrective lenses	<input type="checkbox"/> <input type="checkbox"/>	Nausea	<input type="checkbox"/> <input type="checkbox"/>	Numbness / Tingling	<input type="checkbox"/> <input type="checkbox"/>
Changes in vision	<input type="checkbox"/> <input type="checkbox"/>	Vomiting	<input type="checkbox"/> <input type="checkbox"/>	Nervous / Anxiety	<input type="checkbox"/> <input type="checkbox"/>
Eye pain	<input type="checkbox"/> <input type="checkbox"/>	Diarrhea	<input type="checkbox"/> <input type="checkbox"/>	Depression	<input type="checkbox"/> <input type="checkbox"/>
Redness	<input type="checkbox"/> <input type="checkbox"/>	Constipation	<input type="checkbox"/> <input type="checkbox"/>	Skin	
		Stomach pain	<input type="checkbox"/> <input type="checkbox"/>	Skin changes	<input type="checkbox"/> <input type="checkbox"/>
ENT		Blood in stool	<input type="checkbox"/> <input type="checkbox"/>	Rash / Redness	<input type="checkbox"/> <input type="checkbox"/>
Headaches	<input type="checkbox"/> <input type="checkbox"/>	Difficulty swallowing	<input type="checkbox"/> <input type="checkbox"/>	Musculoskeletal	
Hearing loss	<input type="checkbox"/> <input type="checkbox"/>			<i>(Other than the reason you are here today)</i>	
ringing in ears	<input type="checkbox"/> <input type="checkbox"/>	Excessive thirst	<input type="checkbox"/> <input type="checkbox"/>	Joint pain	<input type="checkbox"/> <input type="checkbox"/>
Dizziness	<input type="checkbox"/> <input type="checkbox"/>	Excessive urination	<input type="checkbox"/> <input type="checkbox"/>	Joint stiffness	<input type="checkbox"/> <input type="checkbox"/>
Hoarse voice	<input type="checkbox"/> <input type="checkbox"/>	Increased appetite	<input type="checkbox"/> <input type="checkbox"/>	Joint swelling	<input type="checkbox"/> <input type="checkbox"/>
Swollen glands	<input type="checkbox"/> <input type="checkbox"/>	Increase sweating	<input type="checkbox"/> <input type="checkbox"/>	Difficulty walking	<input type="checkbox"/> <input type="checkbox"/>
Difficulty swallowing	<input type="checkbox"/> <input type="checkbox"/>				

Please answer all questions.

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 _____

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.

_____	_____
_____	_____
_____	_____

Continue on next page



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: 1/2 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.

James T Mazzara, MD

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