

MAPLETON HILL ORTHOPAEDICS, P.C.

DAVID L. ROTER, M.D.

WILLIAM D. FERRIS, M.D.

DRIGAN D. WIEDER, M.D.

ELIZABETH F. YURTH, M.D.

CONFIDENTIAL - MEDICAL HISTORY

Name: _____ Age: _____ D.O.B. _____ Sex: _____

Who referred you to us? Doctor, Attorney, Friend, Family Member, Etc. _____

DO YOU NOW HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

	Yes	No	Please Explain Yes Answers	Family Members? Please list:
Stroke	_____	_____	_____	_____
Heart Trouble	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____
Arthritis	_____	_____	_____	_____
Gout	_____	_____	_____	_____
Seizures	_____	_____	_____	_____
Trouble with Depression or Nerves	_____	_____	_____	_____
Kidney Trouble	_____	_____	_____	_____
Cancer (If yes, where?)	_____	_____	_____	_____
Bleeding Disorder	_____	_____	_____	_____
Alcoholism	_____	_____	_____	_____
Tuberculosis	_____	_____	_____	_____
Lung Disease (Asthma/Emphysema)	_____	_____	_____	_____
Blood Clots	_____	_____	_____	_____
Anemia (Low Blood)	_____	_____	_____	_____
Ulcers	_____	_____	_____	_____
Liver Disease (Hepatitis)	_____	_____	_____	_____
Thyroid Trouble	_____	_____	_____	_____
Other Major Medical Illness	_____	_____	_____	_____

LIST ALL SURGICAL PROCEDURES

Surgery	Date	LIST ALL HOSPITALIZATIONS Reason for Hospital Stay	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING

Name and Strength	Dosage (# of tablets)	# of times per day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES

Are you allergic to any medications or substances? Yes _____ No _____
If yes, please list below:

Medication	Reaction
_____	_____
_____	_____
_____	_____

Do you Smoke: NEVER _____ PRESENTLY _____ IN THE PAST _____ # OF PACKS PER DAY _____ # OF YEARS _____
ALCOHOL USE: NEVER _____ OCCASIONAL _____ MODERATE _____ HEAVY _____
(1-2 drinks a week) (1-2 drinks a day) (More than 2 drinks a day)

BLOOD TRANSFUSION: YES _____ NO _____ IF YES, DATE _____

Patient Name _____ Date _____

HAVE YOU EVER BEEN TESTED FOR HIV OR AIDS? (OPTIONAL) YES _____ NO _____
DO YOU CONSIDER YOURSELF AT RISK FOR HIV OR AIDS? (OPTIONAL) YES _____ NO _____

Review of Systems:

Have you recently had or do you now have:

Yes	No		Yes	No		Yes	No	
_____	_____	Reading Glasses	_____	_____	Tooth Ache	_____	_____	Frequent Headaches
_____	_____	Change of Vision	_____	_____	Gum Trouble	_____	_____	Blackouts
_____	_____	Loss of Hearing	_____	_____	Nausea/Vomiting	_____	_____	Seizures
_____	_____	Ear Pain	_____	_____	Stomach Pain	_____	_____	Frequent Rash
_____	_____	Hoarseness	_____	_____	Ulcers	_____	_____	Hot or Cold Spells
_____	_____	Nosebleeds	_____	_____	Frequent Belching	_____	_____	Recent Weight Change
_____	_____	Difficulty Swallowing	_____	_____	Frequent Loose Bowels	_____	_____	Nervous Exhaustion
_____	_____	Morning Cough	_____	_____	Frequent Constipation	_____	_____	Trouble Sleeping
_____	_____	Shortness of Breath	_____	_____	Blood in Bowel Movements	_____	_____	Depression
_____	_____	Chills or Fever	_____	_____	Hemorrhoids	_____	_____	Nervous Tension
_____	_____	Heart or Chest Pain	_____	_____	Frequent Urination	_____	_____	Badly Swollen Ankles
_____	_____	Abnormal Heart Beat	_____	_____	Burning on Urination	_____	_____	Difficulty Starting Urination
_____	_____	Calf Cramp w/Walking	_____	_____	Difficulty Stopping Urination	_____	_____	Poor Appetite
_____	_____	Get Up Every Night to Urinate	_____	_____				

CURRENT HEIGHT _____ CURRENT WEIGHT _____

Sport Activities Include: _____

CHIEF COMPLAINT: _____ Date of Injury: _____

Previous injury or problem: _____

Where did injury occur: _____

How did injury occur: _____

Initial Treatment provided by: _____

Treatment Included: x-rays rest ice elevation P.T. crutches cast brace
(Please circle) surgery NSAID pain medications MRI CT

Other: _____

Results: _____ Diagnosis: _____

Further Treatment By: _____ Treatment: _____

Results: _____ Diagnosis: _____

Current Symptoms: _____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, abnormal laboratory test, or medicine change, I will inform the physician at the next appointment without fail.

Date _____ Patient, Parent or Guardian Signature _____