Bayside Orthopaedic Center
MEDICAL INFORMATION REPORT

Date:___________ Chart #____________________

Please ask for assistance if you have any questions while entering your medical history.

Name:______________________________ **Date of Birth:________________**

TODAY's CHIEF COMPLAINT:____

Did you have an injury?__________Where?__________________When?______/______/________

Work related? **Yes** / **NO** **STOP – BE CERTAIN WORK COMP PROCEDURES ARE IN PLACE!**

ALLERGIES **I HAVE NO ALLERGIES_____** Are you allergic to latex? YES / **No**

List foods, drugs, and chemical allergies:____

FAMILY HISTORY – **Please tell us what conditions or chronic illnesses are in your family. Include Diabetes, High Blood Pressure, Cardiac conditions, Respiratory conditions, cancers, bleeding disorders, anesthesia complications:____**

____

PAST MEDICAL HISTORY **____I have NO MEDICAL HISTORY**

Diabetes	Y / N	Heart Disease	Y / N	Anxiety/Stress Issues	Y / N
Stroke	Y / N	Peptic Ulcer Disease	Y / N	Cholesterol	Y / N
High Blood Pressure	Y / N	Blood Clots	Y / N	Asthma	Y / N
Hepatitis B Hep C	Y / N	Anesthesia Complications	Y / N	Bleeding Disorders	Y / N
TB	Y / N	HIV/ AIDS	Y / N	Acid Reflux/Heartburn	Y / N
Pacemaker	**Y / N**	Thyroid disease	Y / N		

PAST SURGICAL HISTORY__ **______I have not had any surgeries.**

Surgeries/Hospitalizations Year Complications

____

____

____

Do you smoke? **Yes** / No If yes, how much?__________ How long?_________ # of years quit_____________

Do you drink alcoholic beverages? **Yes** / No If yes, how often, how much?______________

Do you have a history of drug abuse or addiction? **Yes** / No **If yes, to what?____________________**

Optional: Spiritual History
Your church affiliation:_________________________________
You put your faith in_______________________________
__I rely on prayer
__I would like to understand how my faith affects my health
__I would like to know more about the Christian faith.

Patients Please Note: This information is extremely important. The clinical staff will review this form with you and if any changes or additions are needed, you will be asked to initial them on this form.

By initialing here, I certify that I have reviewed this information with the patient/guardian and it is correct as stated. Any corrections or additions to the Patient's original entries have been initialed by the patient.

______Nurse Interviewer Physician Statement: I have reviewed this information with patient as a part of today's examination.___________

Bayside Orthopaedic, Sports Medicine & Rehabilitation
Patient Medication Log

Patient Name___________________________________Chart #_________

Date Completed:______________

Your Pharmacy of Choice__________________________City___________

Please list ALL Prescription, Over-the Counter, and Herbal/Vitamin Products you are taking AT THIS TIME.

MEDICATION –OTC – HERBALS – VITAMINS - SUPPLEMENTS	PRESCRIBING DOCTOR