BAYSIDE ORTHOPAEDIC SPORTS MEDICINE & REHAB 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:_____Left Right Bilateral

Did you have an injury?_____Where?_____When?_____/_____/_____

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

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

Diabetes	Y / N	Heart Condition	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
Cancer, if yes, Type_____	N	Thyroid disease	Y / N	Glaucoma	Y/ N
Pacemaker	**Y / N**	**Insulin Pump**	**Y / N**	**Other implantable devices?**	**__**

PAST SURGICAL HISTORY **_____I have not had any surgeries.**

Surgeries/Hospitalizations	Year	Complications

Do you use tobacco products? **No** **NEVER** **Yes, Type _____** If yes, how much?_____ How long?_____ # of years quit_____

Do you drink alcoholic beverages? **Yes** / No NEVER If yes, how often, how much?_____

Do you have a history of drug abuse or addiction? **Yes** / No NEVER **If yes, to what?_____**

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:_____

_____

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._____

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Patient Medication Log

Patient Name_____Chart #_____Date:_____

Your Pharmacy of Choice_____City_____

Does your insurance have a Mail order pharmacy option? NO____
___YES If so, with which mail order pharmacy service? _____

Do you have a Pharmacy discount program card? __No ___Yes_____

ALLERGIES **I HAVE NO DRUG OR MEDICATION ALLERGIES_____**

List foods, drugs, and chemical
allergies:_____

ARE YOU ALLERGIC TO LATEX?? YES _____ NO____

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

MEDICATION –OTC – HERBALS – VITAMINS - SUPPLEMENTS	PRESCRIBING DOCTOR