

ROBINWOOD ORTHOPAEDIC SPECIALTY CENTER
 11110 Medical Campus Road, Hagerstown, Maryland
Patient Medical History Form

Name:	
Date of Birth:	Age:
Marital Status:	<input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Single
Occupation:	
Employer:	
Which is your dominant hand?	R / L
Who referred you: _____	
If you were referred, was it by a healthcare provider?:	Yes / No (Circle one)
What problem has prompted your visit today? <i>(If you have more than one problem, please list them in the order of severity)</i>	
■	_____
■	_____
■	_____
■	_____
How long has it been going on?: _____	
If your problem started from an injury, please give the date of the injury and describe briefly what happened:	
If an injury occurred, was it work-related?:	Yes / No
Were you having problems with this area prior to your injury?	Yes / No
Describe:	

If no injury occurred but the symptoms came on suddenly, what were you doing at the time?:

Please circle the words that most closely represent your problem:

Pain-----Instability (buckling, giving way)-----Constant----- Intermittent (comes and goes)-----
sharp-----Dull-----Achy-----Localized-----Radiating-----Shooting-----Burning----- Tingling
Weakness-----Snapping-----Catching-----Locking

If your problem is pain, please grade it on a severity scale of 1 - 10: _____

(1 - 2 tolerable and not affecting activities of daily living, 3 - 4 tell someone about it and take non-narcotic medicine, 5 - 6 take mild narcotic like tylenol with codeine, 7 - 8 got to ER, take strong narcotics like percocet, 9 - 10 get admitted to hospital for pain management)

What makes it worse? (circle all that apply):

prolonged standing-----prolonged sitting-----prolonged walking-----stairs-----squatting-----lifting
carrying-----bending-----reaching: front / side / overhead / behind-----sleeping (i.e. does it cause
you to wake up intermittently?)-----throwing-----running-----swimming-----sports-----
other: _____

What makes it better? (circle all that apply):

Rest-----ice-----stretch-----wrap/brace-----massage-----tylenol-----motrin/advil-----aleve-----
heat-----other: _____

Is there a pattern to your symptoms i.e. worse in the morning out of bed, in the evening after work, during or after exercise, other: _____

Over time, how would you describe your symptoms (choose one):

worsening-----improving-----unchanged

Have you received any treatment?:

Medications (list): _____
physical therapy-----manipulation-----steroid injections-----epidural injection
viscosupplementation injections (e.g. synvisc, suppartz, hyalgan, euflexxer

surgery (list): _____

Are you having any secondary symptoms which you feel are caused by your main problem? (please list):

- _____
- _____

PAST MEDICAL HISTORY

Please circle medical conditions which you have had diagnosed by a physician, treated or untreated:
asthma (steroid treatment: yes / no)-----COPD-----coronary artery disease-----diabetes-----hepatitis
hypertension-----hypercholesterolemia-----liver abnormality-----renal failure-----ulcer-----
sleep apnea (CPAP: yes / no)-----blood clot
gastrointestinal problems (list): _____
heart attack {date(s)}: _____
other: _____

PAST SURGICAL HISTORY (continued)			
<input type="checkbox"/> none	<input type="checkbox"/> Shoulder arthroscopy: (circle): decompression distal clavicle resection rotator cuff repair stabilization other:	<input type="checkbox"/> Knee arthroscopy (circle) ACL reconstruction meniscal repair partial meniscectomy bebridement other	<input type="checkbox"/> Nerve release (circle): R / L cubital tunnel (elbow) R / L carpal tunnel, tarsal tunnel (ankle), other:
<input type="checkbox"/> Lumbar fusion (give levels if known):	<input type="checkbox"/> Lumbar (back) laminectomy / discectomy	<input type="checkbox"/> Cervical neck fusion (give levels):	<input type="checkbox"/> Knee replacement R / L date(s):
<input type="checkbox"/> Knee lateral retinacular release: open / arthroscopic	<input type="checkbox"/> Fracture surgery: body part(s): _____ _____ Any lingering problems: yes / no	<input type="checkbox"/> Hip replacement R / L date(s):	<input type="checkbox"/> Coronary artery bypass grafting (heart bypass) date:
<input type="checkbox"/> Cardiac stenting: date:	<input type="checkbox"/> Cardiac angioplasty	<input type="checkbox"/> Pace maker	<input type="checkbox"/> Defibrillator (placement)
Other surgeries: (please list): ■ _____ ■ _____			
MEDICATION(S)			
Please list all current medications taken along with dose and frequency taken: ▶ _____ dose: _____ frequency: _____ ▶ _____ dose: _____ frequency: _____ ▶ _____ dose: _____ frequency: _____ ▶ _____ dose: _____ frequency: _____ ▶ _____ dose: _____ frequency: _____			
ALLERGIES			
Please list all medications allergies along with the reaction generated: ▶ _____ reaction: _____ ▶ _____ reaction: _____ ▶ _____ reaction: _____			
SOCIAL HISTORY			
Do you live alone? _____ yes / no How many children, if any, do you have? _____ If they are dependent on you and live with you, please list their ages: _____ / _____ / _____ / _____			

SOCIAL HISTORY (continued)		
Do you smoke cigarettes?: Yes / No now / previously Amount per day: _____ Duration (years): _____		
If you quit and not longer smoke, when did you stop? _____		
Do you consume alcohol? Yes / No rare minimal moderate heavy		
FAMILY HISTORY		
Please indicate beside the illness: F = father, M = mother, S = sister, O = other relative:		
<input type="checkbox"/> Arthritis (type, if known: _____)	<input type="checkbox"/> Blood clots	<input type="checkbox"/> Cancer
<input type="checkbox"/> Cardiac disease (heart attack, congenital heart deformity)	<input type="checkbox"/> Other	
REVIEW OF SYMPTOMS		
Are you experiencing any other symptoms which are aggravating your present complaint (i.e. generalized weakness, fatigue, weight loss / gain, breathing problems, bleeding, urinary, depression)? Yes / No If yes, please explain:		
Height: _____	Weight: _____	
Clinician Signature: _____	Date: _____	



DR. B. EDWARDS, MD
DR. J. N. HOLOBINKO, MD
DR. R. KOSURI, MD
DR. G. SHERMAN, MD
DR. M. WINSLOW, MD
DR. S. WORRELL, MD
DR. M. YACYK, DO

J. BUTERBAUGH, PA-C
G. MAZZONE, PA-C
S. TAYLOR, PA-C
C. PASKANIK, CRNP

Please identify the location of your symptoms on the diagram.

