IMPORTANT:
Please check the appropiate box(es) taht relate to your medical history or condition

Mid Island Orthopedics and Physical Therapy
Jeffrey S. Sider, MD
Medical History Form

Patient:___________________________ Date______________________

Chief Complaint:_______________________________________
Have you had any x-rays or lab work done related to this complaint? _Yes _No
If yes where and when"____

Height ______________ Weight________________________

History of Present Complaint:____
Location of pain:____
How severe is the pain, or problem?____
Is this due to Work related injury __ Auto Accident____
Does the pain/problem occur at a specific time? If yes, when?________________________________
What other signs or symptoms are you having?____
How long have you this pain/problem?____
Have you had any previous episodes? If yes, when?____

Are you allergic to any medications? If yes please list and give reaction:____
Are you taking any Herbal Supplements/Vitamins, if yes please list____

Patient Medical History: (Circle one)

Diabetes	No Yes	Hypertension	No Yes
Cancer	No Yes	Heredity Defects Stroke	No Yes
Heart Disease	No Yes	Arthritis/Gout	No Yes
Convulsions	No Yes	Bleeding Tendency	No Yes
Asthma	No Yes	Thyroid Disease	No Yes
Stroke	No Yes	Vascular disease	No Yes

Medications dosage:____
____
Past Surgical History:____

Patient Social History
Marital Status: Single__ Married:__Separated:__ Divorced: __Widowed:__
Use of Alcohol: Never: __Rarely:__ Moderate: __Daily:__
Use of Tobacco: Never:__ Previously, but quit:___ Current:____ # of packs per day___

Family Medical History:

	Age	Diseases	If deceased, Cause of death
Mother:	______	_________________________	_________________________________
Father:	______	_________________________	_________________________________
Siblings:	______	_________________________	_________________________________
Children:	______	_________________________	_________________________________

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Review of Systems:

Eyes	
Injury	( )
Trauma	( )
Retinal detachment	( )
Glaucoma	( )
Cataracts	( )

ENTM	
Wear hearing aids	( )
Hearing loss	( )
Ear pain	( )
Ear infections	( )
Ringing in the ears	( )
( ) Right ( ) Left	
Balance disturbance	( )
Dizziness	( )
Nosebleeds	( )
Nasal congestion	( )
Nasal drainage	( )
Inability to smell	( )
Sinus problems	( )
Frequent sore throat	( )
Mouth sores	( )

Cardiovascular	
Chest pain or angina	( )
High blood pressure	( )
Irregular pulse	( )
Heart murmur	( )
Swelling of hands/feet	( )
Leg cramps/pain	( )
Color change of feet	( )

Constitiutional symptoms
Good general health lately ()
Recent weight change ()
Fever()
Fatigue()

Respiratory	
Sleep Apnea	( )
Chronic cough	( )
Bloody sputum	( )
Difficulty breathing	( )
Wheezing	( )
Emphysema	( )
History of pneumonia	( )
Lung cancer	( )

Gastrointestinal	
Indigestion	( )
Jaundice	( )
Frequent nausea	( )
Liver disease	( )
Abdominal pain	( )
Change in bowel habit	( )
Ulcers or gastritis	( )
Colon cancer	( )

Genitourinary	
Painful urination	( )
Incontinence	( )
Kidney stones	( )

Musculoskeletal	
Arm/leg weakness	( )
Back pain	( )
Arm or leg pain	( )
Join pain/swelling	( )
Joint Stiffness	( )
Cold Extremities	( )

Integumentary	
Rash or Itching	( )
Change in skin color	( )
Varicose Veins	( )

Neurological	
Fainting spells	( )
Blacking out	( )
Seizures	( )
Headaches	( )
Memory loss	( )
Face weakness	( )
Speech problem	( )
Paralysis	( )
Tremors	( )
Numbness or tingling	( )
Stroke	

Psychiatric	
History of mental illness	( )
Depression	( )
ADD	( )

Endocrine	
Diabetes	( )
Thyroid disease	( )
Increased appetite	( )
Weakness	( )
Weight loss	( )
Weight gain	( )
Change of skin color	( )

Hematological/Lymphatic	
Low blood count	( )
Hemophilia	( )
Bleeding tendencies	( )
Blood transfusion	( )
Slow to heal after cuts	( )
Bleeding/Bruising	( )
Anemia	( )
Phlebitis	( )
Transfusions	( )

Allergy/Immunology	
Eczema	( )
Hives	( )
Frequent sneezing	( )
Food allergies	( )
Drug allergies	( )
Latex	( )

Date________________________