RAINIER
ORTHOPEDIC INSTITUTE
A Division of Proliance Surgeons, Inc., P.S.

MEDICAL HISTORY

Please take the time to fill in all the blank spaces.
Use black or blue ink only.

Ht. _____
Wt. _____
BP _____

Date _____ Referred by _____ Primary Physician _____

Name (First, Middle, Last): _____ Birthdate _____ Age _____

Reason for appointment (Please specify diagnosis or region of the body): _____

Pharmacy: Name _____ Address _____

PAST MEDICAL HISTORY

Allergies: _____ **Latex and/or Metal Allergy:** ❑ **Yes** ❑ **No Reaction** _____

Current Medications and dosage: _____

_____

_____

_____

Surgical History: (operations, dates, complications): _____

_____

Medical Problems/Hospitalizations: _____

_____

Special Diet: ❑ Yes ❑ No _____ **Regular Exercise:** ❑ Yes ❑ No (x/week) _____

Sports Activities: _____

SOCIAL HISTORY

_____

Marital Status: _____ Level of Education: _____ Special Needs ❑ Yes ❑ No

Occupation: _____ Employer _____ Last Day of Work _____

Tobacco: ❑ Yes ❑ No Packs Per Day: _____ If you have stopped, how long ago? _____

Smokeless Tobacco: ❑ Yes ❑ No ❑ Former user

Alcohol: ❑ Yes ❑ No Drinks Per Week _____ Coffee: ❑ Yes ❑ No No Cups Per Day: _____

Drug Use ❑Yes ❑ No Drugs Used and When _____

COMPLETE REVIEW OF MEDICAL HISTORY

For each of the following Categories, please CIRCLE any symptoms or conditions you have now or have had recently. Please place a CHECK by any symptoms or conditions you are currently experiencing:

CONSTITUTIONAL
Unexplained weight loss
Loss of energy
Loss of appetite
Fever or chills
History of cancer (type)
_____
Trouble with anesthesia
Other _____

EYES/EARS/NOSE/THROAT
Loss or change of vision
Eye pain or redness
Glaucoma
Cataracts
Double or blurred vision
Loss of Hearing
Buzzing or noise in the ear
Ear infection or drainage
Hoarseness
Congestion
Nose bleeds
Difficulty swallowing
Other _____

CARDIOVASCULAR
High blood pressure
Heart attack
Heart murmur
Chest pain
Abnormal heartbeat
Rheumatic fever
Calf "cramps" with walking
Sensitivity of fingers/toes to cold
Varicose veins
Swollen ankles and feet
Poor circulation
Pass out / Fainting
Elevated Cholesterol

RESPIRATORY
Asthma
Emphysema
Sleep apnea
Severe snoring
Wheezing
Chronic cough
Large quantity of sputum
Night sweats
Pneumonia
Tuberculosis
Last pneumonia vaccine_____
Last flu vaccine _____
Other _____

GASTROINTESTINAL
Heartburn or reflux
Gallbladder disease
Recurring diarrhea
Frequent constipation
Loss of bowel control
Hernia
Digestive difficulties
Frequent nausea or vomiting
Frequent abdominal pain
Bloody vomit
Bloody stools
Hemorrhoids
Hepatitis
Other _____

GENITOURINARY
Urinary incontinence or dribbling
Bloody urine
Increased frequency of urination
Decreased stream
Difficulty urinating
Kidney stones
Frequent UTI

FEMALE ONLY
Painful menses or excess bleeding
Pregnancy or possibility
Uterine fibroids or tumors
Breast pain
Difficulty in sexual functioning
Last Menstrual Period _____
Last mammogram _____

MALES ONLY
Penile pain
Abnormality of testicles
Scrotal swelling
Varicocele
Difficulty with sexual functioning
Other _____

SKIN
Chronic rash
Psoriasis
Poor wound healing
History of skin ulcers
Chronic fungal infections
Other _____

ENDOCRINE
Diabetes
Hyper thyroidism
Hypo thyroidism
Osteoporosis
Hormone imbalance
Other _____

HEMATOLOGIC/LYMPH
Blood disorder
Anemia or low blood count
Blood clot/DVT/PE
Easy bruising
Excessive bleeding
Swollen lymph glands
Other _____

ALLERGY/IMMUNE
Hay fever or allergies
Food allergies
Immune disorder
Recurring infections
HIV
Other _____

PSYCHOLOGICAL
Depression
Excessive worry or anxiety
Severe tension
History of abuse
Feeling of hopelessness/worthlessness
Difficulty sleeping
Emotional problems
Other _____

NEUROLOGICAL
Stroke
Seizures or convulsions
Shaking or twitching spells
Frequent or severe headaches
Dizziness
Paralysis
Other _____

MUSCULOSKELETAL
Gout
Arthritis
Inflammatory arthritis
Neck pain
Back pain
Sciatica
Spine abnormality
Tendonitis
Bursitis
History of polio
Torn ligaments/muscles/tendons
Numbness or tingling
Last Dexascan _____

Signature: _____

Name of person completing this form if other than patient: _____

Relationship to patient: _____

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MEDICAL HISTORY

Please take the time to fill in all the blank spaces.
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FAMILY MEDICAL HISTORY: **Your name**_____

Please put the Correlating number beside each medical condition that applies:

1= Mother 2= Father 3=Maternal Grandmother 4=Maternal Grandfather

5=Sister 6=Brother 7=Paternal Grandmother 8=Paternal Grandfather

9=Other Family Member Example: X--- PMS 1,5 *(for mother & sister)*

__Alcoholism_____

__Anesthetic complications_____

__Anemia_____

__Anxiety_____

__Arthritis_____

__Asthma_____

__Birth Defect_____

__Bleeding Disease_____

__Breast Cancer_____

__Colon Cancer_____

__Depression_____

__Diabetes_____

__Heart Disease_____

__High Cholesterol_____

__Hypertension_____

__Kidney/Renal Disease_____

__Lung/Respiratory Disease_____

__Migraines_____

__Osteoporosis_____

__Other Cancer_____

__Angina_____

__Cervical Cancer_____

__Coronary Heart Disease_____

__Endometriosis_____

__Growth Development Disorder_____

__Headaches_____

__Lung Cancer_____

__Melanoma_____

__Other Med Problems_____

__Ovarian Cancer_____

__PMS_____

__Psychiatric Care_____

__Uterine Cancer_____

__ Weight Disorder_____

__Seizures_____

__Severe Allergies_____

__Stroke/CVA_____

__Thyroid Disorder