

Green Bay Orthopedics, LTD/ General & Vascular, Consultants, LLC

PATIENT NAME: _____ DOB: _____ AGE: _____ DATE: _____

FAMILY MD: _____ ADDRESS: _____ PHONE: _____

REFERRED BY: _____ ADDRESS: _____ PHONE: _____

CHIEF COMPLAINT: _____

How and when did problem begin? (please be specific) _____

OCCUPATION: _____

Describe occupation: _____

HEALTH HISTORY—PATIENT/FAMILY			
YES PT	YES Pt Family	NO	Heart Problems
YES PT	YES Pt Family	NO	High Blood Pressure/Stroke
YES PT	YES Pt Family	NO	Diabetes
YES PT	YES Pt Family	NO	Arthritis/Gout
YES PT	YES Pt Family	NO	Ear/Nose/Throat Problems
YES PT	YES Pt Family	NO	Sinus Problems
YES PT	YES Pt Family	NO	Seizures/Epilepsy
YES PT	YES Pt Family	NO	Depression/Mental Illness
YES PT	YES Pt Family	NO	Kidney/Stone Problems
YES PT	YES Pt Family	NO	Cancer
YES PT	YES Pt Family	NO	Bleeding/Blood Clot Problems
YES PT	YES Pt Family	NO	Hormone Disorders
YES PT	YES Pt Family	NO	Lung Disease (Asthma, TB, Shortness of Breath, etc.
YES PT	YES Pt Family	NO	Headaches
YES PT	YES Pt Family	NO	Stomach/Intestinal Problems
YES PT	YES Pt Family	NO	Liver/Jaundice Trouble
YES PT	YES Pt Family	NO	Thyroid Problems
YES PT	YES Pt Family	NO	Skin Disorder
YES PT	YES Pt Family	NO	Muscle Disease
YES PT	YES Pt Family	NO	Bone Disorder/Pain/Osteoporosis
YES PT	YES Pt Family	NO	Eye Problems/Glasses/Contacts
YES PT	YES Pt Family	NO	Anesthesia Problems
YES PT	YES Pt Family	NO	Fractures
YES PT	YES Pt Family	NO	Joint Pain/Swelling

PAST SURGERIES/MEDICAL HISTORY
HEIGHT: _____ WEIGHT: _____
Past Surgeries/Date _____

Past Medical History: _____

Allergies: _____

Present Medications and Dosage: _____

WOMEN: Are/Could you be pregnant? _____
Smoking History: _____
_____ Cigs/Packs per Day for _____ Years
Alcohol: _____
Exercise: time per week _____

If accident Injury: _____
Date of Injury: _____
Place of Injury: _____
Work Related? Yes / No
If Yes, Please Explain: _____

The information I provided on this Medical History form is true to the best of my knowledge and belief.

PATIENT SIGNATURE _____ DATE _____

PHYSICIAN'S SIGNATURE _____ DATE _____

REVIEWED AND UPDATED (Phy Initials) _____ DATE _____

REVIEWED AND UPDATED (Phy Initials) _____ DATE _____