ADVANTAGE
ORTHOPEDIC AND SPORTS MEDICINE CLINIC
24076 S.E. Stark, Suite 110
Gresham, Oregon 97030
Phone (503)661-5388
Fax (503)666-9393

MEDICAL HISTORY

NAME: _____ ☐ MALE ☐ FEMALE DATE: _____

PLEASE DESCRIBE THE PROBLEM AND SYMPTOMS YOU ARE SEEING THE DOCTOR FOR TODAY:

_____

_____

REFERRED BY: _____ FAMILY PHYSICIAN: _____

PHARMACY: _____

HEIGHT: _____ WEIGHT: _____ BMI: _____ AGE: _____

LIST **ALL ALLERGIES & REACTION**: _____

_____

PLEASE LIST **ALL MEDICATIONS** (PRESCRIPTION & NON-PRESCRIPTION) THAT YOU ARE CURRENTLY TAKING:

1. _____	4. _____	7. _____	10. _____
2. _____	5. _____	8. _____	11. _____
3. _____	6. _____	9. _____	12. _____

FAMILY HISTORY: ☐ Cancer ☐ Diabetes ☐ Heart Disease Who in your family? _____

SOCIAL HISTORY:

Occupation: _____ Employer: _____

Do you smoke? How much? _____	☐ YES	☐ NO	Do you drink? How much? _____	☐ YES	☐ NO
Do you exercise? How much? _____	☐ YES	☐ NO	Hand Dominance	☐ Right	☐ Left
Work related injury?	☐ YES	☐ NO	Auto related injury?	☐ YES	☐ NO

LIST ALL PAST SURGERIES (WITH DATE, IF KNOWN)

_____

_____

_____

PAST MEDICAL HISTORY

HAVE YOU HAD, OR DO YOU PRESENTLY SUFFER FROM: (mark boxes Y/N)

AIDS/HIV	☐ YES	☐ NO	High Blood Pressure (HTN)	☐ YES	☐ NO
Alcoholism	☐ YES	☐ NO	High Cholesterol	☐ YES	☐ NO
Anemia	☐ YES	☐ NO	Hyper Thyroid	☐ YES	☐ NO
Angina	☐ YES	☐ NO	Hypo Thyroid	☐ YES	☐ NO
Anxiety	☐ YES	☐ NO	Implantable Cardiac Defibrillator (ICD)	☐ YES	☐ NO
Arthritis	☐ YES	☐ NO	Kidney Disease	☐ YES	☐ NO
Asthma	☐ YES	☐ NO	Kidney Stones	☐ YES	☐ NO
Atrial Fibrillation	☐ YES	☐ NO	Liver Disease (Cirrhosis)	☐ YES	☐ NO
Benign Prostatic Hypertrophy	☐ YES	☐ NO	Lyme Disease	☐ YES	☐ NO
Bladder Infection	☐ YES	☐ NO	MRSA Infections	☐ YES	☐ NO
Bleeding Disorder	☐ YES	☐ NO	Meniere's disease	☐ YES	☐ NO
Blood Clot (DVT)	☐ YES	☐ NO	Migraines	☐ YES	☐ NO
Blood Transfusion	☐ YES	☐ NO	Obesity	☐ YES	☐ NO
COPD	☐ YES	☐ NO	Orthotics	☐ YES	☐ NO
Cancer	☐ YES	☐ NO	Osteoarthritis	☐ YES	☐ NO
Chemical Dependency	☐ YES	☐ NO	Osteopenia	☐ YES	☐ NO
Chronic Low Back Pain	☐ YES	☐ NO	Osteoporosis	☐ YES	☐ NO
Chronic Pain	☐ YES	☐ NO	Pacemaker	☐ YES	☐ NO
Coronary Artery Disease	☐ YES	☐ NO	Peripheral Vascular Disease	☐ YES	☐ NO
Depression	☐ YES	☐ NO	Psoriasis	☐ YES	☐ NO
Diabetes	☐ YES	☐ NO	Psoriatic Arthritis	☐ YES	☐ NO
Fibromyalgia	☐ YES	☐ NO	Pulmonary Embolism	☐ YES	☐ NO
Gastro Esophageal Reflux Disease (GERD)	☐ YES	☐ NO	Rheumatoid Arthritis	☐ YES	☐ NO
Gout	☐ YES	☐ NO	Seizures/Epilepsy	☐ YES	☐ NO
Heart Arrythmia	☐ YES	☐ NO	Sleep Apnea	☐ YES	☐ NO
Heart Attack (MI)	☐ YES	☐ NO	Stroke (CVA)	☐ YES	☐ NO
Heart Failure (CHF)	☐ YES	☐ NO	Transient Ischemic Attack (TIA)	☐ YES	☐ NO
Heart Problems	☐ YES	☐ NO	Tuberculosis	☐ YES	☐ NO
Hepatitis	☐ YES	☐ NO	Ulcers	☐ YES	☐ NO

LIST ANY OTHER MEDICAL PROBLEMS NOT MENTIONED ABOVE:

_____

_____

_____

REVIEW OF SYSTEMS

HAVE YOU HAD, OR DO YOU PRESENTLY SUFFER FROM: (PLEASE CIRCLE ALL THAT APPLY)

CONSTITUTIONAL:	no complaints fever night sweats weight gain (__lbs) weight loss (__lbs) exercise intolerance
EYES:	no complaints dry eyes irritation vision change
EARS:	no complaints difficulty hearing ear pain
NOSE:	no complaints frequent nosebleeds nose problems
MOUTH/THROAT:	no complaints sore throat bleeding gums snoring dry mouth oral abnormalities mouth ulcer teeth abnormalities mouth breathing
CARDIOVASCULAR:	no complaints chest pain on exertion shortness of breath when walking shortness of breath when lying down palpitations known heart murmur light-headed on standing
RESPIRATORY:	no complaints wheezing shortness of breath coughing up blood sleep apnea
GASTROINTESTIONAL:	no complaints change in appetite black or tarry stools frequent diarrhea vomiting blood dyspepsia GERD
GENITOURINARY:	no complaints urinary loss of control increased urinary frequency hematuria incomplete emptying changes in urinary habits
MUSCULOSKELETAL:	no complaints muscle aches muscle weakness arthralgias/joint pain back pain swelling in the extremities
SKIN:	no complaints jaundice rash itching dry skin growths/lesions
NEUROLOGIC:	no complaints loss of consciousness weakness numbness seizures dizziness frequent or severe headaches migraines restless legs tremor
PSYCH:	no complaints depression sleep disturbances restless sleep alcohol abuse anxiety hallucinations
ENDOCRINE:	no complaints fatigue increased thirst hair loss increased hair growth cold intolerance
HEMATOLOGIC/ LYMPHATIC:	no complaints swollen glands easy bruising excessive bleeding
ALLERGY/ IMMUNOLOGIC:	no complaints runny nose sinus pressure itching frequent sneezing

PATIENT SIGNATURE: _____ DATE: _____