Proliance
Rainier Orthopedic Institute

MEDICAL HISTORY

Ht. __________
Wt. __________
BP __________

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

Date ______________ Referred by ________________________ Primary Physician ________________________

Name (First, Middle, Last) ____ Birthdate ____________________

Age __________ Birth Sex: ____________________________ Current Gender: ___________________________

Pharmacy: Name ____ Address ____________________________

Reason for appointment (Please specify diagnosis or region of the body ____________________________________

PAST MEDICAL HISTORY

Current Medications and dosage: ____

____

____

____

Allergies: __________________________ **Latex and/or Metal Allergy:** ☐ **YES** ☐ **NO Reaction** ______________

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
Chills
Loss of energy (fatigue)
Fever
Night sweats
Unexplained weight loss
Loss of appetite

EYES/EARS/NOSE/THROAT
Blurred vision
Double Vision
Difficulty swallowing
Ear infection or drainage
Loss of hearing
Hoarseness
Congestion
Buzzing or ringing in the ear
Loss or change of vision
Eye pain or redness
Nose Bleeds

RESPIRATORY
Sleep Apnea
Chronic Cough
Asthma
Severe snoring
Large quantity of sputum
Wheezing

CARDIOVASCULAR
Chest Pain
Heart murmur
Swollen ankles and feet
Abnormal heartbeat
Pass out/fainting
Calf "cramps" with walking
Sensitivity of fingers/toes to cold
Varicose veins*
Poor circulation

GASTROINTENSTINAL
Frequent abdominal pain
Frequent Constipation
Bloody stools
Recurring diarrhea
Heartburn or reflux
Frequent nausea or vomiting
Bloody vomit
Loss of bowel control
Hemorrhoids

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

ENDOCRINE
Cold or heat intolerant
Hair Loss
Increased thirst

COMPLETE REVIEW OF MEDICAL HISTORY (CONTINUED)

NEUROLOGICAL
Dizziness
Seizures or convulsions
Frequent or severe headaches
Headaches or migraines

PSYCHOLOGICAL
Anxiety
Depression
Difficulty sleeping
Severe tension
Feelings of hopelessness/ worthlessness

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

MUSCULOSKELETAL
Back pain
Neck stiffness or pain
Sciatica
Spine Abnormality

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

ALLERGY/IMMUNE
Food allergies
Seasonal allergies
Immune disorder
Recurring Infections

Medical Problems/Hospitalizations:

Arthritis (Type)______________
Blood disorder
Bursitis
Cancer History (Type)_________
Cataracts
Diabetes
Digestive difficulties
DVT/Blood Clot
Elevated Cholesterol
Emphysema
Gallbladder disease
Glaucoma
Gout
Heart Attack
Hepatitis
Hernia
High blood pressure
History of Abuse
History of Polio
HIV
Hormone Imbalance
Hyperthyroidism
Hypothyroidism
Kidney stones
Osteoporosis
Paralysis
Pneumonia
History of Polio
Rheumatic fever
Stroke
Tendonitis
Torn ligaments/muscles/tendons
Trouble with anesthesia
Tuberculosis
Varicose Veins

Other: ____

____

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

____

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: ____________________________________

Signature: ____

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

Relationship to patient: ____

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FAMILY MEDICAL HISTORY

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

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