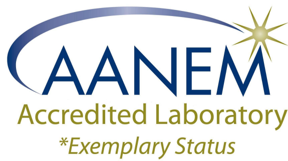

Comprehensive Orthopaedics, S.C.

Raymond Rybicki, M.D. FABEM

•Neurology • Spine • Peripheral Nerve • Carpal Tunnel Syndrome • Low Back Pain • Neck Pain • Peripheral Neuropathy • Tarsal Tunnel Syndrome • EMG/NCV Procedures • EEG Procedures • Evoked Potentials •

PATIENT MEDICAL HISTORY – LONG FORM

Today's Date ____________________

Last Name ____ First ______________________________ MI ______

Date of Birth ______________________________Age______ Height ________ Weight ______ € Male € Female

Occupation ______________________________________

CURRENT MEDICAL ISSUE (S)

____

____

____

2 MEDICATIONS AND ALLERGIES

CURRENT MEDICATIONS

List all medications that you are taking (prescriptions and over-the-counter) including aspirin, vitamins, etc.

Medication	Mg	Daily Dose	How Often
1______________________________	__________	______________	________
2______________________________	__________	______________	________
3______________________________	__________	______________	________
4______________________________	__________	______________	________
5______________________________	__________	______________	________
6______________________________	__________	______________	________
7______________________________	__________	______________	________
8______________________________	__________	______________	________

ALLERGIES

List medications or injections that have given you bad reactions. List the reaction (hives, welts, rash, itching, headache, nausea, diarrhea, passing out, shock, shortness of breath)

Medication or injection	Reaction	Year
1______________________________	____________________________	________
2______________________________	____________________________	________
3______________________________	____________________________	________
4______________________________	____________________________	________

3 PAST MEDICAL HISTORY

Operations/Accidents	Hospital	Year
1________________	________________	______
2________________	________________	______
3________________	________________	______
4________________	________________	______
5________________	________________	______

Hospitalizations	Hospital	Year
1________________	________________	______
2________________	________________	______
3________________	________________	______
4________________	________________	______

List medical problems not requiring hospitalization such as chronic headaches, rheumatic fever, diabetes, high blood pressure, tuberculosis, hepatitis, kidney stones, gallstones, ulcers, etc.

Problem	Treatment	Year
1________________	________________	______
2________________	________________	______
3________________	________________	______
4________________	________________	______
5________________	________________	______

4 SOCIAL HISTORY

Do you smoke? € No € Yes How Long: ____________ How Much: __________

What do you smoke? € Cigarettes € Cigars € Pipe

Have you stopped? € No € Yes When: __________

Do you drink alcohol? € No € Yes How Long: __________

How Much? € 1 drink/day € 2 oz./day € 4 oz./day € More

Have you ever used: € Marijuana € Heroine € Cocaine € LSD/PCP € Other

Have you visited outside the U.S. in the last 6 months? € No € Yes

5 FAMILY MEDICAL HISTORY

	Male	Fem	Age	Health Problems	Age/death	Cause/death
Father			____	________________	_____	__________
Mother			____	________________	_____	__________
Spouse	€ M	€ F	____	________________	_____	__________
Siblings	1 € M	€ F	____	________________	_____	__________
	2 € M	€ F	____	________________	_____	__________
	3 € M	€ F	____	________________	_____	__________
	4 € M	€ F	____	________________	_____	__________

FAMILY MEDICAL HISTORY-continued

	Male	Fem	Age	Health Problems	Age/death	Cause/death
Children	1 € M	€ F	____	______________________________	_____	_________________
	2 € M	€ F	____	______________________________	_____	_________________
	3 € M	€ F	____	______________________________	_____	_________________
	4 € M	€ F	____	______________________________	_____	_________________

IMMEDIATE FAMILY MEDICAL ISSUES – Include relationship to you

€ Anemia ________________________
€ Alcoholism ______________________________
€ Bleeding Disorders ________________________
€ Brain Tumor ______________________________
€ Cancer ________________________
€ Diabetes ______________________________
€ Heart Problems ________________________
€ High Blood Pressure__________________________
€ Migraines ________________________
€ Multiple Sclerosis____________________________
€ Muscle Disease ________________________
€ Muscular Dystrophy__________________________
€ Seizures ________________________
€ Stroke _____________________________________

6 REVIEW OF SYSTEMIC SYSTEMS

CONSTITUTIONAL

Check Yes or No to any of the following that you have now or have recently had:

€ Yes € No Chills
€ Yes € No Weakness
€ Yes € No Fever
€ Yes € No Fatigue
€ Yes € No Weight Loss
€ Yes € No Weight Gain
€ Yes € No Decline in Health

GENITOURINARY – WOMEN ONLY

€ Yes € No Birth Control
€ Yes € No Hernias
€ Yes € No Change in Periods-Flow
€ Yes € No Menopause
€ Yes € No Difficult Pregnancy
€ Yes € No Menstrual Pain
€ Yes € No Postmenopausal Bleeding
€ Yes € No Change in Periods-Interval
€ Yes € No Sexual Problems
€ Yes € No Discharge
€ Yes € No Bleeding Between Periods
€ Yes € No Itching
€ Yes € No Recent Pap Smear
€ Yes € No Fertility Problems
€ Yes € No Venereal Disease
€ Yes € No Lesions
€ Yes € No Change in Periods-Duration
€ Yes € No Pain on Intercourse
€ Yes € No DES Exposure
€ Yes € No Recent Pregnancy

GENITOURINARY – MEN ONLY

€ Yes	€ No	Discharge	€ Yes	€ No	Venereal Disease
€ Yes	€ No	Impotence	€ Yes	€ No	Fertility Problems
€ Yes	€ No	Prostate Problems	€ Yes	€ No	Lesions
€ Yes	€ No	Scrotal Masses	€ Yes	€ No	Pain
€ Yes	€ No	Hernias	€ Yes	€ No	Sexual Problems

URINARY

€ Yes	€ No	Awakening to Urinate	€ Yes	€ No	Infections
€ Yes	€ No	Burning	€ Yes	€ No	Stones
€ Yes	€ No	Flank Pain	€ Yes	€ No	Urine Odor
€ Yes	€ No	Bed Wetting	€ Yes	€ No	Pain on Urination
€ Yes	€ No	Difficulty Starting Stream	€ Yes	€ No	Urgency
€ Yes	€ No	Frequency	€ Yes	€ No	Blood in Urine
€ Yes	€ No	Excessive Urination	€ Yes	€ No	Retention
€ Yes	€ No	Incontinence	€ Yes	€ No	Urine Discoloration

HEAD

€ Yes	€ No	Dizziness	€ Yes	€ No	Head Injury
€ Yes	€ No	Headaches	€ Yes	€ No	Sweats
€ Yes	€ No	Fainting	€ Yes	€ No	Pain

PSYCHIATRIC

€ Yes	€ No	Depression	€ Yes	€ No	Excessive Stress
€ Yes	€ No	Disturbing Thoughts	€ Yes	€ No	Mood Changes
€ Yes	€ No	Memory Loss	€ Yes	€ No	Disorientation
€ Yes	€ No	Psychiatric Disorders	€ Yes	€ No	Hallucinations
€ Yes	€ No	Behavioral Change	€ Yes	€ No	Nervousness

NEUROLOGICAL

€ Yes	€ No	Loss of Consciousness	€ Yes	€ No	Blackouts
€ Yes	€ No	Dizziness	€ Yes	€ No	Fainting
€ Yes	€ No	Headaches	€ Yes	€ No	Memory Loss
€ Yes	€ No	Paralysis	€ Yes	€ No	Speech Disorders

NEUROLOGICAL continued

€ Yes	€ No	Tingling	€ Yes	€ No	Tremors
€ Yes	€ No	Burning	€ Yes	€ No	Head Injury
€ Yes	€ No	Numbness	€ Yes	€ No	Strokes
€ Yes	€ No	Unsteady Gait			

RESPIRATORY

€ Yes	€ No	Asthma	€ Yes	€ No	Coughing of Blood
€ Yes	€ No	Bronchitis	€ Yes	€ No	Pain
€ Yes	€ No	Pleurisy	€ Yes	€ No	Positive TB Test

RESPIRATORY-continued

€ Yes	€ No	Shortness of Breath	€ Yes	€ No	Sputum
€ Yes	€ No	Cough	€ Yes	€ No	Wheezing
€ Yes	€ No	Recent Chest X-Ray	€ Yes	€ No	Tuberculosis

CARDIOVASCULAR

€ Yes	€ No	Chest Pain	€ Yes	€ No	Heart Tests (Not EKG)
€ Yes	€ No	Extremities (cool)	€ Yes	€ No	Leg Pain-Walking
€ Yes	€ No	Heart Murmur	€ Yes	€ No	Shortness of Breath-Exertion
€ Yes	€ No	History of Heart Attack	€ Yes	€ No	Swelling of Legs
€ Yes	€ No	Rheumatic Fever	€ Yes	€ No	Varicose Veins
€ Yes	€ No	Shortness of Breath-Sleeping	€ Yes	€ No	Hair Loss on Legs
€ Yes	€ No	Ulcers on Legs	€ Yes	€ No	High Blood Pressure
€ Yes	€ No	Palpitations	€ Yes	€ No	Recent Electrocardiogram
€ Yes	€ No	Extremities Discolored	€ Yes	€ No	Shortness of Breath-Lying Flat
€ Yes	€ No	Thrombophlebitis			

GASTROINTESTINAL

€ Yes	€ No	Abdominal Pain	€ Yes	€ No	Change in Stool Color
€ Yes	€ No	Heartburn	€ Yes	€ No	Excessive Hunger
€ Yes	€ No	Rectal Bleeding	€ Yes	€ No	Hemorrhoids
€ Yes	€ No	Black Tarry Stools	€ Yes	€ No	Laxative Use
€ Yes	€ No	Swallowing Problems	€ Yes	€ No	Change in Frequency of BM
€ Yes	€ No	Constipation	€ Yes	€ No	Change in Stool Consistency
€ Yes	€ No	Jaundice	€ Yes	€ No	Excessive Thirst
€ Yes	€ No	Abdominal X-Ray Tests	€ Yes	€ No	Hepatitis
€ Yes	€ No	Nausea	€ Yes	€ No	Antacid Use
€ Yes	€ No	Vomiting	€ Yes	€ No	Change in Stool Caliber
€ Yes	€ No	Diarrhea	€ Yes	€ No	Decreased Appetite
€ Yes	€ No	Liver Disease	€ Yes	€ No	Gallbladder Disease
€ Yes	€ No	Infections	€ Yes	€ No	Rectal Pain
€ Yes	€ No	Vomiting Blood			

MUSCULOSKELETAL

€ Yes	€ No	Arthritis	€ Yes	€ No	Back Problems
€ Yes	€ No	Muscle Cramps	€ Yes	€ No	Restricted Motion
€ Yes	€ No	Joint Pain	€ Yes	€ No	Deformities
€ Yes	€ No	Muscle Stiffness	€ Yes	€ No	Weakness
€ Yes	€ No	Gout	€ Yes	€ No	Joint Stiffness
€ Yes	€ No	Paralysis			

ENT

NOSE

€ Yes € No Discharge
€ Yes € No Infections
€ Yes € No Sinus Infections
€ Yes € No Frequent Colds
€ Yes € No Nasal Obstruction
€ Yes € No Hay Fever
€ Yes € No Nose Bleeds

MOUTH

€ Yes € No Bleeding Gums
€ Yes € No Post Nasal Drip
€ Yes € No Change in Dentition
€ Yes € No Tongue Burning
€ Yes € No Hoarseness
€ Yes € No Voice Changes

EARS

€ Yes € No Discharge
€ Yes € No Hearing Impairment
€ Yes € No Ringing in Ears
€ Yes € No Pain
€ Yes € No Dizziness
€ Yes € No Infections
€ Yes € No Hearing Aid

THROAT NECK

€ Yes € No Frequent Sore Throats
€ Yes € No Tonsils Enlarged
€ Yes € No Lumps
€ Yes € No Tenderness

ALLERGIC/IMMUNOLOGIC

€ Yes € No Coughing
€ Yes € No Itchy Eyes
€ Yes € No Runny Nose
€ Yes € No Watery Eyes
€ Yes € No Coughing With Exercise
€ Yes € No Itchy Nose
€ Yes € No Sneezing
€ Yes € No Wheezing
€ Yes € No Hives
€ Yes € No Recurrent Infections
€ Yes € No Stuffy Nose
€ Yes € No Wheezing With Exercise

ENDOCRINE

€ Yes € No Weakness
€ Yes € No Cold Intolerance
€ Yes € No Goiter
€ Yes € No Neck Pain
€ Yes € No Weight Gain
€ Yes € No Excessive Urination
€ Yes € No Heat Intolerance
€ Yes € No Sweats
€ Yes € No Weight Loss
€ Yes € No Fatigue
€ Yes € No Increased Thirst
€ Yes € No Thyroid Trouble

HEMATOLOGIC/LYMPH

€ Yes € No Anemia
€ Yes € No Easily Bruised
€ Yes € No Swollen Glands
€ Yes € No Blood Clots
€ Yes € No Bleeding Easily
€ Yes € No Lumps
€ Yes € No Transfusion Reaction
€ Yes € No Radiation Exposure

SKIN

€ Yes € No Eczema
€ Yes € No Hair Dye

€ Yes	€ No	Easily Bruised	€ Yes	€ No	Lumps
€ Yes	€ No	Hives	€ Yes	€ No	Nail Texture Change
€ Yes	€ No	Nail Appearance Change	€ Yes	€ No	Dryness
€ Yes	€ No	Skin Color Change	€ Yes	€ No	Hair Texture Change
€ Yes	€ No	Itching	€ Yes	€ No	Mole Increased Size
€ Yes	€ No	Rashes			

EYES

€ Yes	€ No	Blurry Vision	€ Yes	€ No	Eyeglass Use
€ Yes	€ No	Double Vision	€ Yes	€ No	Pain with Light
€ Yes	€ No	Unusual Sensations	€ Yes	€ No	Vision Loss
€ Yes	€ No	Cataracts	€ Yes	€ No	Discharge
€ Yes	€ No	Excessive Tearing	€ Yes	€ No	Eye Pain
€ Yes	€ No	Glaucoma	€ Yes	€ No	Infections
€ Yes	€ No	Recent Injury	€ Yes	€ No	Redness

BREASTS

€ Yes	€ No	Discharge	€ Yes	€ No	Tenderness
€ Yes	€ No	Self-Examination	€ Yes	€ No	Pain
€ Yes	€ No	Lumps			

ADDITIONS, OTHER COMMENTS OR NOTES:

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