Medical History

CORE ORTHOPEDICS
Avera Medical Group
2908 E. 26th Street ◆ Sioux Falls, SD 57103

Name: _____ Date: _____

Medication	Dosage
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	
13.	

Medication	Dosage
14.	
15.	
16.	
17.	
18.	
19.	
20.	
21.	
22.	
23.	
24.	
25.	
26.	

Pharmacy name: _____

ALLERGIES/Explain Reaction:

_____ _____

_____ _____

Past Medical History _____

_____

_____

Review of Systems

Check all symptoms/conditions you currently have or have had in the past and explain:

- ❑ **Thyroid Disease**_____
- ❑ **Diabetes**_____
- ❑ **Heart Disease**_____
- ❑ **Heart Murmur**_____
- ❑ **Valve Problems**_____
- ❑ **High Blood Pressure**_____
- ❑ **Chest Pain**_____
- ❑ **Dizziness**_____
- ❑ **Fracture/Broken Bone**
  Body Part_____
- ❑ **Joint Pain**
  Body Part_____
- ❑ **Joint Swelling**
  Body Part_____
- ❑ **Back Pain/Injury**_____
- ❑ **Neck Pain/Injury**_____
- ❑ **Osteoporosis**_____
- ❑ **Carpal Tunnel**_____
- ❑ **Rheumatoid Arthritis** _____
- ❑ **Multiple Sclerosis**_____
- ❑ **Parkinsons**_____
- ❑ **Stroke**_____
- ❑ **Seizure**_____
- ❑ **Nervous Disorder**_____
- ❑ **Epilepsy**_____
- ❑ **Headaches Cough Blood**_____
- ❑ **Asthma or Emphysema**_____
- ❑ **Pneumonia**_____
- ❑ **Lung Disease**_____
- ❑ **Ulcers**_____
- ❑ **Rectal Bleeding**_____
- ❑ **Change in Bowel Habits**_____
- ❑ **Hepatitis (Jaundice or Liver Disease)**
- ❑ **Gallbladder Disease**_____
- ❑ **Heartburn**_____
- ❑ **Double Vision**_____
- ❑ **Nosebleeds**_____
- ❑ **Difficulty Swallowing**_____
- ❑ **Hoarsness**_____
- ❑ **Ringing in the ears**_____
- ❑ **Infections after Surgery**_____
- ❑ **Venereal Disease**_____
- ❑ **Hepatitis** _____
- ❑ **(HIV) AIDS**_____
- ❑ **Oseomyelitis**_____
- ❑ **Kidney Stones**_____
- ❑ **Blood in Urine**_____
- ❑ **Painful Urination**_____
- ❑ **Frequent Rashes**_____
- ❑ **Skin Irritation**_____
- ❑ **Swelling of the Feet**_____
- ❑ **Paralysis**_____
- ❑ **Numbness**_____
- ❑ **Depression**_____
- ❑ **Schizophrenia**_____
- ❑ **Bipolar Disorder**_____
- ❑ **Drug or Alcohol Abuse**_____
- ❑ **Other Please Explain**_____

_____

_____

Reviewed by Provider: _____ Date: _____

Medical History

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Name: _____ Date: _____

Surgeries/Hospitalizations/Illness	Year
1.	
2.	
3.	
4.	
5.	

6.	
7.	
8.	
9.	
10.	
11.	

Have you ever had general anesthesia? ❑ No ❑ Yes
Have any problems with anesthesia? ❑ No ❑ Yes Describe: _____
Have you ever had a blood transfusion? ❑ No ❑ Yes
Date of last tetanus booster: _____

Family History

Member	Age	Living	Deceased	Health Status or Cause of Death
Father		L	D	❑ Heart Disease ❑ Diabetes ❑ Cancer (location_____) ❑ Stroke ❑ High Blood Pressure ❑ Thyroid Disease Other_____
Mother		L	D	❑ Heart Disease ❑ Diabetes ❑ Cancer (location_____) ❑ Stroke ❑ High Blood Pressure ❑ Thyroid Disease Other_____
Sister/Brother		L	D	❑ Heart Disease ❑ Diabetes ❑ Cancer (location_____) ❑ Stroke ❑ High Blood Pressure ❑ Thyroid Disease Other_____
Sister/Brother		L	D	❑ Heart Disease ❑ Diabetes ❑ Cancer (location_____) ❑ Stroke ❑ High Blood Pressure ❑ Thyroid Disease Other_____
Sister/Brother		L	D	❑ Heart Disease ❑ Diabetes ❑ Cancer (location_____) ❑ Stroke ❑ High Blood Pressure ❑ Thyroid Disease Other_____

Social History

Occupation: _____ Employer: _____ Length of employment _____

Marital Status_____

Exercise (Type/Frequency) _____ Are you on a special diet? Describe _____

History of Illegal drug abuse: ❑ No ❑ Yes Describe_____

Smoke currently: ❑ No ❑ Yes ____ packs per day for ____ years Year you quit smoking _____

Alcohol Use: ❑ No ❑ Yes ❑ 1-2 per week ❑ 3-5 per week ❑ 1-3 per month Other _____

I certify the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions I may have made in the completion of this form.

Patient Signature: _____ Date: _____

Reviewed by Provider: _____ Date: _____