BERKSHIRE ORTHOPAEDIC ASSOCIATES, INC.

MEDICAL HISTORY FORM

Patient's Name: _____ Date of Birth: _____

Emergency Contact: _____ Relationship: _____ Phone#: _____

Primary Care Physician: _____ Referring Physician: _____

Dentist: _____ Patient Height: _____ Patient Weight: _____

Reason for visit: _____

Date of Injury/Onset: _____ ☐ MVA ☐ Work Related

Have you had the pneumonia vaccine? ☐ YES ☐ NO

Have you had the flu vaccine? ☐ YES ☐ NO

Have you had a colonoscopy for colorectal cancer screening? ☐ YES ☐ NO

Have you had a mammography for breast cancer screening? ☐ YES ☐ NO

Review of System: (Check all that apply)

___Headaches	___Stomach, ulcer, intestinal problems	___Anemia
___Seizures	___Cholesterol	___Cancer
___Strokes	___Breathing or lung disorders	___Hepatitis
___Arthritis	___Kidney/Bladder problems	___Phlebitis/blood clots
___Nerve disorders	___Thyroid problems	___Ease of bruising
___Circulation problems	___Diabetes, ☐ Type 1 ☐ Type 2	___Prolonged bleeding from cuts
___Heart trouble	___High blood pressure	___Emotional or psychiatric difficulties
___ Pregnancy	___Gout	___Seasonal allergies/ Asthma

Any other medical problems:_____

Past Surgical History: _____

_____

Social History: (please circle) Single/Married Children: ☐ YES ☐ NO

Alcohol Consumption: _____ Tobacco: _____ Recreational Drugs: _____

Family Medical History: _____

_____

Allergies to Medications: _____

Reaction to the above allergies? :_____

Current Medications: (If you have a list of medications, we will be happy to copy it.)

_____

_____

Patient Signature: _____ Date: _____