J. Richard Well MD Orthopeadics, P.C.

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MEDICAL HISTORY

All information contained in this questionnaire are strictly confidential and will become part of your medical record.

Full Name____ Date________________

Social Security Number______________________________ Date of Birth______________

Why are you seeing the Doctor?____
____

Is the current problem a result of:

☐ Car accident ; ☐ Work Injury; ☐ Slip and Fall; ☐ Other___________________________

Please describe how this current injury occurred.____
____

Are you presently taking medication or including over the counter and/or alternative medications?

☐ Yes; ☐ No; If yes please list below

____

Are you allergic to any medications or had any problems with the following? ☐ Yes; ☐ No;

If yes, list here ____

Are you currently having or have you had any problems with the following? If yes describe

Bladder Problems	☐ Yes;	☐ No;	______________________________
Bowel Movements	☐ Yes;	☐ No;	______________________________
Lung Breathing	☐ Yes;	☐ No;	______________________________
Diabetes	☐ Yes;	☐ No;	______________________________
High blood Pressure	☐ Yes;	☐ No;	______________________________
Bleeding problems	☐ Yes;	☐ No;	______________________________
Numbness Tingling	☐ Yes;	☐ No;	______________________________
Blackout Fainting	☐ Yes;	☐ No;	______________________________
Arthritis	☐ Yes;	☐ No;	______________________________
AIDS/HIV	☐ Yes;	☐ No;	______________________________
Cancer	☐ Yes;	☐ No;	______________________________
Epilepsy	☐ Yes;	☐ No;	______________________________
Hepatitis	☐ Yes;	☐ No;	______________________________
TB	☐ Yes;	☐ No;	______________________________
MS	☐ Yes;	☐ No;	______________________________

Any other information regarding your health that we should know? ____________________________
____

Past Medical History

Surgeries/Hospitalization	Year	Complications

Have you ever had general anesthesia? ☐ Yes; ☐ No;
Have you ever had any problems with anesthesia? ☐ Yes; ☐ No; If yes, describe below

____

Family History

	Alive	Deceased	Age	Health Status
Grandmother (mom's) ………	A	D	____	____________________
Grandmother (dad's) ………	A	D	____	____________________
Grandfather (mom's) ………	A	D	____	____________________
Grandfather (dad's) ……...	A	D	____	____________________
Father …………………………	A	D	____	____________________
Mother ………………………..	A	D	____	____________________
Sister/Brother ………………..	A	D	____	____________________
Sister/Brother ………………..	A	D	____	____________________
Sister/Brother ………………..	A	D	____	____________________

Social History

☐ Work in the home ☐ Employed full time ☐ Employed part time ☐ Student

Children? ☐ Yes ☐ No

Do you live alone? ☐Yes ☐ No

How often do you Exercise? ____

Are you Currently on a special diet? ☐Yes ☐ No Describe ______________________________

History of substance abuse? ☐ Yes ☐ No; If, yes, what? ______________________________

Do you smoke? ☐ Yes ☐ No; If yes, how much per day? ______________________________

Do you drink? ☐ Yes ☐ No how much and how often?______________________________

____

Reviewed by Dr. Wells____________________ **Date** ____________________