UB MD ORTHOPAEDICS & SPORTS MEDICINE

Patient Medical History Update

Last Name:_____First Name: _____MI: _____Today's Date: _____

DOB:_____Age:_____Height: _____Weight: _____

ALLERGIES: ☐**None** ☐Penicillin ☐Sulfa ☐Aspirin ☐Nickel ☐Dye ☐Codeine ☐Latex ☐Iodine ☐Egg ☐Shellfish ☐Pollen

☐Other Allergies Not Listed:_____

MEDICATIONS: List medications (*including over the counter medications, such as vitamins, Tylenol, etc.)* Please provide a typed medication list if necessary or use reverse side.

Drug	Dosage	How Taken *(with meals, as needed, etc)*	Reason

Have you had any changes in your medical history (Major illnesses, surgery/operations, hospitalizations, current ongoing illness - e.g. diabetes)

since your last appointment? ☐No ☐Yes - If yes, please describe: _____

Have you had a new injury since your last appointment? ☐No ☐Yes

Is your injury the result of an automobile or work accident? ☐No ☐Yes - If yes: ☐Auto ☐Work

PRESENTING PROBLEM

Why are you seeing the doctor today?

Shoulder ☐Right ☐ Left **Elbow** ☐Right ☐ Left **Wrist** ☐Right ☐ Left **Hand** ☐Right ☐ Left **Hip** ☐Right ☐ Left

Leg ☐Right ☐ Left **Knee** ☐Right ☐ Left **Ankle** ☐Right ☐ Left **Foot** ☐Right ☐ Left **Neck** ☐ **Back/Spine** ☐ **Concussion** ☐

My injury is: ☐ Work Related from __/___/_____ ☐ Due to a Car Accident from __/___/_____☐ Sports Injury from __/_____/_____

☐ Other Injury from _____/___/_____☐ No Known Specific Injury/Onset was: ☐Gradual ☐Sudden

*Please specify how your injury occurred:*_____

_____

In your own words, please describe your chief complaint: _____

_____

Have you had any diagnostic studies other than routine x-rays? ☐ No ☐ Yes - If yes, where was the study performed: _____

If yes, what type: ☐MRI ☐CT ☐Bone Scan ☐Ultrasound ☐EMG ☐Other: _____

What other doctors have you seen for your current problem? (e.g. chiropractor) _____

Have you done any formal physical therapy for your current problem? ☐No ☐Yes - If yes, for how long:_____

Have you had surgery for this current problem? ☐No ☐Yes - If yes, when:_____

Have you missed work as a result of this problem? ☐No ☐Yes - If yes, when: _____

Occupation: _____ **Employer:**_____

Current Work Status: ☐ Full Time ☐ Part Time ☐Not Working due to this injury ☐Not Working for other reasons

☐ Working with restrictions ☐ Disabled ☐ Unemployed ☐ Retired

The information on this form has been completed accurately to the best of my knowledge. I understand it is my responsibility to inform the doctor's office of any change in my information.

_____ _____ Date:_____

Print Name of Patient or Parent/Legal Guardian (if patient is under 18 years of age)

Signature

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