Capitol Orthopaedics and Rehabilitation, LLC

MEDICAL HISTORY INFORMATION **Legacy ID:**

Name:

Height:_______ Weight:_______ Marital Status: □ M □ S □ D □ W

Do you reside in a Skilled Nursing Facility (Permanently or Temporarily)? □ Yes □ No
Name of facility:____

Primary Care Physician: _________________________Referred by: ______________________

Your Occupation:______________________________ Are you □ Right or □ Left handed?

What body part is involved? _________________________ □ Right □ Left □ Bilateral
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Type of accident, if applicable: □ Auto Accident □ Worker's Comp □ Other____________

Details of Injury/Accident:

How did it happen? ____

Where did it happen? ____

When did it happen? ____
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On a scale of 0 – 10, with 10 being the worst pain ever felt, how severe is the pain? ____

Type of pain: □ Dull □ Sharp □ Aching □ Shooting □ Burning □ Other ______________

Duration of pain is: □ Constant □ Intermittent

Does your pain wake you up from sleep? □ Yes □ No □ Occasionally

Do you experience pain when: (Check all that apply)

□ Lifting □ Reaching □ Throwing □Squa

□ Standing □ Walking □ Running □ Other_____________________________

Do you experience any of the following symptoms: (Check all that apply)

□ Weakness □ Instability □ Swelling □ Clicking □ Numbness □ Night Pain □ Stiffness

□ Loss of Range of Motion □ Catching □ Tingling □ Other _____________________________
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What treatment and/or tests have you had for this problem? (Check all that apply)

□ X-rays □ MRI □ EMG □ Physical Therapy □ Injections □ Surgery □ Other ______________

When and Where were they performed? ____

Drug Allergies: □ None □ Yes (Please List): _______________________________________

ALL Current Medications and Dosage: □ None □ Yes (Please List)_________________________

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ANY Prior Surgery and date: □ None □ Yes (Please List) _________________________________

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Do you:

Smoke (chew) tobacco products? ☐ Current Every Day smoker ☐ Current Someday Smoker
☐ Never Smoker ☐ Former Smoker ☐ Status Unknown

What year did you: Start: ___________ Stop: __________ Still Smoking ___ pack(s) per day

Drink Alcohol? ☐ Yes ☐ No How often? ____ Per day / week

Take Illegal drugs? ☐ Yes ☐ No How often? ____ Per week

Exercise? ☐ Yes ☐ No How often? ____ Per week

Indicate type of exercise: ____

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Family Medical History: Please complete any relevant information

	M	F	Living	Current Diagnosis	Deceased	Year of Death	Cause of Death
Mother		X					
Father	X						
Sibling							
Sibling							
Additional							

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Your Review of Systems: Please check any symptoms you have experienced:

☐ Except as noted **Review Of Systems** is negative

Constitutional: ☐ Fever ☐ Wt loss ☐ Headache	**Integumentary/Skin**: ☐ Rash ☐Boils ☐ Persistent itch
Eyes: ☐↓ Vision ☐Pain ☐ Diplopia	**Muscoskeletal**: ☐ Back pain ☐ Neck pain ☐ Joint pain
ENT: ☐↓ Hearing ☐ Sinus Problems ☐ Sore throat	**Neurology**: ☐ Seizures☐ Tremors ☐ Dizzy spells
Respitory: ☐ Shortness of breath ☐ Wheezing ☐ Frequent.cough	**Endocrine**: ☐ Excessive thirst ☐ Too hot/cold ☐ Tired/sluggish
Cardiac: ☐ Chest pain ☐ Irregular heartbeat ☐ Leg swelling	**Hemat/Lymphatic**: ☐ Swollen glands ☐ Blood Clotting Problem
Immunological: ☐ Hay Fever ☐ Drug Allergies	**Psychological**: ☐ Depression ☐ Anxious ☐ Nervous
Gastrointestinal: ☐ Nausea ☐ Abd pain ☐ Indigestion/Heartburn	**Genitourinary**: ☐ Dysuria ☐ Urgency ☐ Frequency ☐ Hematuria

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****__Your Past Medical History of__: (Check all that apply)

☐ Anemia
☐ Asthma/Emphysema
☐ Cancer
☐ Colitis
☐ Depression/Anxiety

☐ Diabetes
☐ Gall Bladder Disease
☐ Glaucoma
☐ Gout/ High Uric Acid
☐ Heart Disease

☐ Hepatitis
☐ High Blood Pressure
☐ HIV / AIDS
☐ Kidney Stone

☐ Lung Disease
☐ Lyme Disease
☐ Seizures
☐ Stroke
☐ Tuberculosis

☐ Thyroid Disease
☐ Ulcers
☐ Vertigo
☐ Other
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Patient's Signature: ____ Date: ________________

Doctor's Signature: ____

Capitol Orthopaedics and Rehabilitation, LLC

Neil J. Barkin, MD, FAAOS
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Victor A. Wowk, MD, FAAOS

In Association With:

Marc J. Grossman, MD

Notice to Patients

Due to an increasing frequency of patients missing scheduled appointments, we are forced to institute a policy. If you fail to appear for a scheduled appointment there will be a $50 charge that must be collected before further treatment can be provided. To avoid this charge, you must notify the office at (301) 770-7900 at least 24 hours prior to your scheduled appointment. These calls must be received during normal business hours, which are 8AM to 4:30 PM, Monday through Friday.

Similarly, copays must be paid on the date of service prior to the initiation of treatment.

We regret having to initiate this policy but the frequent missed appointment rate both threatens the viability of this orthopaedic office and prevents patients who are seeking care from receiving timely treatment.

I have read the above, recognize this policy, and agree to abide by it.

Signed______________________________________ Date__________________

Printed Name:____

Witness____

Account No:______________________________