TALLGRASS
ORTHOPEDIC &
SPORTS MEDICINE

Patient Medical Profile

Patient Name:_____

REVIEW OF SYSTEMS

Do you currently have any of these problems?

Constitutional
Fatigue ❑ Yes ❑ No
Fever ❑ Yes ❑ No
Night sweats ❑ Yes ❑ No

HEENT
Headache ❑ Yes ❑ No
Visual loss ❑ Yes ❑ No

Respiratory
Cough ❑ Yes ❑ No
Short of breath ❑ Yes ❑ No

Cardiovascular
Chest pain ❑ Yes ❑ No
Blue skin color ❑ Yes ❑ No
Irregular heartbeat ❑ Yes ❑ No

Gastrointestinal
Constipation ❑ Yes ❑ No
Diarrhea ❑ Yes ❑ No
Nausea ❑ Yes ❑ No
Vomiting ❑ Yes ❑ No

Genitourinary
Painful urination ❑ Yes ❑ No
Blood in urine ❑ Yes ❑ No

Endocrine
Cold intolerant ❑ Yes ❑ No
Heat intolerant ❑ Yes ❑ No

Neurologic
Difficulty walking ❑ Yes ❑ No
Dizziness ❑ Yes ❑ No

Integumentary
Skin rash ❑ Yes ❑ No

Hematologic
Easy bleeding ❑ Yes ❑ No
Easy bruising ❑ Yes ❑ No

Immunologic
Environment allergy ❑ Yes ❑ No
Food allergy ❑ Yes ❑ No

MEDICAL HISTORY

Please select any problems you currently have or have had in the past.

❑ Aids/HIV
❑ Alcoholism
❑ Anemia
❑ Arthritis
❑ Asthma
❑ Atrial fibrillation
❑ Blood clots / DVT
❑ Cancer (type):_____
❑ Congestive heart failure
❑ COPD
❑ Depression
❑ Diabetes Taking insulin? ❑Y ❑N
❑ Drug abuse
❑ Fibromyalgia
❑ Fracture (location):_____
❑ Gout
❑ Heart disease / attack
❑ Heartburn
❑ Hepatitis (type):_____
❑ Hypertension
❑ High cholesterol
❑ Kidney disease
❑ Liver disease
❑ Osteoporosis
❑ Rheumatoid arthritis
❑ Seizure disorders
❑ Stomach (peptic) ulcer
❑ Stroke
❑ Thyroid problems
❑ **NONE OF THESE APPLY TO ME**
❑ Other_____
_____

SURGICAL HISTORY

Please list all previous surgeries and the approximate year: ❑ **I HAVE NOT HAD ANY SURGERIES**

Surgery:	Year:	Surgery:	Year:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

FAMILY HISTORY

Please check the box if anyone in your immediate family (parents, brothers, sisters, children) have any of the following.

❑ Ankylosing spondylitis, who?_____
❑ Asthma, who?_____
❑ Blood clots, who?_____
❑ Cancer, who?_____
❑ Diabetes, who?_____
❑ Gout, who?_____
❑ Heart disease, who?_____
❑ Hypertension, who?_____
❑ Kidney disease, who?_____
❑ Liver disease, who?_____
❑ Lupus, who?_____
❑ Osteoarthritis, who?_____
❑ Osteoporosis, who?_____
❑ Rheumatoid arthritis, who?_____
❑ **NONE OF THESE APPLY TO ME**
❑ Other_____
_____
_____

SOCIAL HISTORY

Have you ever used tobacco: ❑ Yes ❑ No ❑ Unknown

Current tobacco use status:
❑ Current every day smoker / user
❑ Former smoker / user
❑ Light or occasional smoker / user

Do you drink alcohol:
❑ Yes ❑ No
❑ Formerly Year quit:_____

SIGNATURE

To the best of my knowledge, the questions on this form have been answered accurately. It is my responsibility to inform the doctor of any changes in my medical status.

_____ _____
Signature of Patient (parent or guardian if the patient is a minor) Date