**Orthopaedic Associates of Arkansas**
**Medical History Questionnaire**

Date: ____________
Chart #: ____________

Last Name ________________________ First ________________________ M. I. ________

Female / Male    Date of Birth    Age Today

**Reason for Your Physician Office Visit** (Please describe your symptoms)

_______________________________________________

_______________________________________________

**Is this a chronic medical condition?** Yes No **Problem side:** Right / Left / Both Sides
**Date symptom(s) and problem(s) began:** ______ / ______ / ______
**Is this an injury from an accident?** Yes No **Is this a work related injury?** Yes No
**Are you actively working?** Yes No **If no, how long off?** Weeks Months Years
**Worker's Compensation?** Yes No **Occupation** ________________________

**Have you been consulted by another physician for this problem(s)?** Yes No
**If yes, physician's name.** ________________________ **Date consulted?** ______ / ______ / ______

**Have you had any tests or labs associated with this problem(s)?** Yes No Please check all that apply.
**Xray** ☐ **CT Scan** ☐ **MRI** ☐ **EMG/NCS** ☐ **Other** ☐ ________________________ Date: __________

**Please indicate your pain level, right now? (Please circle a number below to indicate your pain level)**
0 1 2 3 4 5 6 7 8 9 10
(No Pain)→→→→→→→→→→→→→→→→→→→→→→→→→→→→→→→→(Worst pain possible)

**Do you have any allergies?** Yes No **List each allergy w/ reactions?** ________________________

**List all medications including over that counter medications:** ________________________

**Do you smoke?** Yes No **Do you drink?** Yes No **How often?** _______ **Are you pregnant?** Yes No
**Do you have any of the following medical conditions? (Please check all that apply.)**

- ☐ Heart trouble / chest pain
- ☐ Diabetes
- ☐ High blood pressure
- ☐ Lung disease
- ☐ Kidney disease
- ☐ Cancer What type? ________________________
- ☐ Other ________________________
- ☐ Gout
- ☐ Pace Maker
- ☐ Seizure
- ☐ Stroke
- ☐ Arthritis
- ☐ Thyroid disease
- ☐ Blood disease / anemia
- ☐ Anticoagulation therapy / Blood thinners
- ☐ Asthma
- ☐ Jaundice / hepatitis
- ☐ Stomach ulcers
- ☐ High Cholesterol

**Is there a family history of any of the above medical condition(s) (mother, father, siblings, and / or grandparents)?** Yes No
Please identify which medical condition(s) and which family member(s): ________________________

Please list all minor and major surgeries: ________________________

Who is your regular doctor?    Who referred you to us?

OAA use only: Initial:    Weight:    Height:    Blood Pressure:

I have read and reviewed this information with the patient.
Practitioner's Signature: ________________________ Date: ____ / ____ / ____
Practitioner's Printed Name: ________________________