



PALM BEACH ORTHOPAEDIC INSTITUTE, P.A.

MEDICAL HISTORY - FOLLOW UP

Name: _____ Age: _____ MR# _____ Today: __/__/__

This form will greatly aid the Doctor in your Orthopaedic care. We appreciate your time and help with providing this information.

Chief Complaint: _____ Date of Injury: __/__/__
W: ___ lbs H: ___' ___" DOB: __/__/__

History of Present Illness

*Please **circle** below and/or **add** any additional information needed.

1. Where is your injury / problem / pain (body part)? _____

2. Has your current problem become:

worse better becoming more frequent stayed the same other: _____

3. How often do you experience the symptoms/ pain/ problem?

Constantly off and on during activity/ sports /exercise at night other: _____

4. Are you or have you experienced any:

bruising swelling redness rashes ringing numbness weakness other: _____

5. What level of pain do you experience?

0 1 2 3 4 5 6 7 8 9 10

6. Have you found anything that helps to improve the symptoms/ Pain / problem?

ice heat rest elevation therapy medication other: _____

Past Medical History

SINCE YOUR LAST VISIT have there been any **CHANGES** in your health:

Please explain: _____

List any **NEW** medications you are currently taking: _____

Please list any **NEW** food or drug allergies: _____

List any medications you are no longer taking since your last visit: _____

Please list any surgical procedures or hospitalizations since your last visit: _____



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Review of Systems

SINCE YOUR LAST VISIT have there been any CHANGES in your health:

- | | | | |
|-----------------------------|------------------------------|-----------------------------|-------|
| Respiratory Problems? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Cardiovascular Problems? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Gastrointestinal Problems? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Genital / Urinary Problems? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Neurological Problems? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Emotional Problems? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Bleeding Disorders? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Skin Problems? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Eye Problems? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |

Medical Insurance

Have there been any changes to your medical insurance since your last visit?

Yes No Explain: _____

Patient Signature
Reviewed with patient and/or family member

Physician Signature

Date: ___/___/___