UNIVERSITY of MARYLAND
UPPER CHESAPEAKE HEALTH

Orthopaedic Specialty Group Medical Questionnaire

Date: _____/_____/_____

Patient Name: _____ DOB: ____/____/____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

SS#: _____-_____-_____ Home Phone: _____ Cell Phone: _____

May we contact you by email? Yes No Email Address: _____ *(please print)*
Marital Status: M / D / S / W Do you live alone? Yes No Veteran: Yes No
Height: _____ Weight: _____ Gender: Male Female Other
Race: _____ Hispanic or Latino? Yes No Language: _____

Referred by: _____ Primary Care Physician: _____
Local Pharmacy: _____ Location: _____ Phone #:_____

Reason for today's visit: _____ Left Right Bilateral (*circle one*)
Injury related to: Work / Liability / Auto / None (*circle one)*
Duration: _____ (days, weeks, months, years) **Pain: Mild Moderate Severe (*circle one*)**
Date of Injury: _____

Medication ALLERGIES or attach list: _____
_____
Medication(s) with dosage or attach list: _____
_____
List ALL surgeries with date including left or right: _____
_____
_____
_____

History of blood clots? Yes No

Do you take any blood thinners? Yes No Name of blood thinner: _____

Women - last menstrual period? _____

Pain Management: Yes No Name of physician: _____ Phone #: _____

Patient Name: _____ **DOB**: _____ /_____ /_____

MEDICAL HISTORY – ***please check all that apply***

CARDIOVASCULAR	**YES**	**RESPIRATORY**	**YES**	**PYSCHIATRIC**	**YES**
Hypertension (high blood pressure)		Asthma		Depression	
High Cholesterol		COPD		Anxiety	
Heart Attack		Oxygen Use		PTSD	
Congestive Heart Failure				Bipolar	
Stroke		**NEUROLOGICAL**			
Pacemaker		Migraines		**ALLERGY TO:**	
Cardiac Stent		Seizure		Chicken	
Bypass Surgery		Parkinson's		Eggs	
		Dementia		Latex	
ENDOCRINE		Alzheimer's			
Diabetes		Neuropathy			
Hyperthyroidism					
Hypothyroidism		**HEMATOLOGICAL/LYMPHATIC**			
		Anemia			
GASTROINTESTINAL		Bleeding Disorder			
Acid Reflux		Cancer (If so where and when):			
Hepatitis					
Irritable Bowel		TB			
		AIDS/HIV			
MUSCULOSKELETAL					
Arthritis		**GENITOURINARY**			
Rheumatoid		Bladder Problems			
Osteoporosis		Prostate Problems			
Osteopenia					
		OTHER HEALTH CONCERNS:			
CONSTITUTIONAL		1)			
Weight Loss		2)			
Weight Gain		3)			

SOCIAL HISTORY – ***please circle your answers and complete where necessary***

Employment Status:	Employed / Retired / Student / Unemployed / Disabled
***Employer*:**	***Occupation*:**
Exercise:	Daily / Weekly / Monthly / Rarely / Never
Sports:	No / Yes – School / Club / Recreational - ***What type?***:
Alcohol:	No / Yes – Daily / Weekly / Monthly / Yearly - ***How many drinks per week?***:
Smoking Status:	Never / Current / Former – ***How long since you quit?***:
Substance Abuse:	No / Yes – **W*hat substance and when?***:

FAMILY HEALTH HISTORY - ***please list medical conditions below****

Father: _____ Mother: _____

Brother: _____ Sister: _____

Other: _____