PLYMOUTH OFFICE
41 Resnik Road
Plymouth MA 02360
Phone: 781.934.2400

DUXBURY OFFICE
95 Tremont Street
Duxbury MA 02332
Phone: 781.934.2400

SANDWICH OFFICE
290 Route 130
Sandwich MA 02563
Phone: 781.934.2400

PATIENT MEDICAL HISTORY FORM

PATIENT INFORMATION

Name: ______________________ DOB: __________ SS#: __________

Primary Care Physician and Address: ______________________

____

Referring Physician (s) if other than Primary Care Physician and Address: ______________________

____

Chief Complaint: ______________________

MEDICAL INFORMATION

Have you ever been treated for any of the following medical conditions: (please check all that apply)

Diagnosis:

- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis/Joint Pain
- ☐ Asthma
- ☐ Cancer, Type ______
- ☐ Clotting/Bleeding Problems
- ☐ Depression
- ☐ Diabetes
- ☐ DVT/Blood Clots/Phlebitis
- ☐ Emphysema
- ☐ Fractures/Broken Bones
- ☐ Gout
- ☐ Heart Disease/Attack
- ☐ Hepatitis
- ☐ High Blod Pressure
- ☐ High Cholesterol
- ☐ HIV Disease
- ☐ Kidney Disease/Urinary Issues
- ☐ Osteoporosis
- ☐ Reflux
- ☐ Stoke/CVA
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcers

Symptoms:

- ☐ Unplanned Weight Loss
- ☐ Fevers
- ☐ Headaches
- ☐ Dizziness/Fainting
- ☐ Chest Pain
- ☐ Swelling of Arms/Legs
- ☐ Blurred Vision
- ☐ Hearing Loss
- ☐ Problems with Anesthesia

Other: ______________________

____

____

____

MEDICATIONS

List all of your current medications and doses: (Include over the counter, vitamins, herbal medications, ect.)

__________ __________ __________

__________ __________ __________

ALLERGIES

Are you allergic to Latex? ☐ Yes ☐ No

Are you allergic to any medications? ☐ Yes ☐ No (If yes please list)

__________ __________ __________

__________ __________ __________

Continued

PLYMOUTH BAY ORTHOPEDIC ASSOCIATES, INC.

FAMILY HISTORY

Do you know of any blood relatives who have or have had the following: (check all that apply)

- ☐ Asthma
- ☐ Aneurysm
- ☐ Brain Tumor
- ☐ Cancer, Type ______
- ☐ Diabetes
- ☐ Epilepsy/Seizers
- ☐ Headaches
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Lung Disease
- ☐ Migraine
- ☐ Multiple Sclerosis
- ☐ Psychiatric Disease
- ☐ Stroke
- ☐ Thyroid
- ☐ None
- ☐ Unknown

SURGICAL HISTORY

Please list past surgeries with approximate date:

______________________ ______________________ ______________________

______________________ ______________________ ______________________

SOCIAL HISTORY

Are you right or left handed? ☐ Right ☐ Left

Do you smoke? ☐ Yes ☐ No If Yes, how many cigarettes/day? __________ Are you interested in quitting? ☐ Yes ☐ No

Do you consume alcohol? ☐ Yes ☐ No If Yes, how much and frequency? ______________________

Do you use recreational drugs? ☐ Yes ☐ No If Yes, what type and frequency? ______________________

Please list any activites you take part in (hobbies, sports):

______________________ ______________________ ______________________

______________________ ______________________ ______________________

By signing, I certify that the information listed above is complete and accurate to the best of my knowledge.

______________________________ ______________

Signature of Patient Date

PHYSICIAN NOTES: