James T. Galyon, M.D.
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Peter B. Lindy, M.D.

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Bartlett, Tennessee 38133
(901) 791-0347

# MEDICAL HISTORY

(Please Print)

| Patient Name: | Age: | Date of Birth: |
|---|---|---|
| Referring Physician: | Primary Care Physician: | |
| Reason for seeking medical attention (chief complaint): | Date of injury or duration of symptoms: | |
| Which extremity are we seeing you for? ☐Right ☐Left ☐Both Dominant hand? | Auto related? ☐Yes ☐No | |
| If injured is litigation ongoing? ☐Yes ☐No | Work related? ☐Yes ☐No | |
| Current Occupation: | Employer: | |
| Have you had any diagnostic studies for this condition? ☐X-rays ☐MRI ☐Bone Scan ☐CT Scan ☐Other: | | |
| Education: Grades completed? College? ☐No ☐Yes If "YES" years attended? | | |

List CURRENT medications you take and dosage:
______________________________________________
______________________________________________
______________________________________________
______________________________________________
______________________________________________

List any MEDICINE ALLERGIES you have:
______________________________________________
______________________________________________
______________________________________________
______________________________________________

List ORTHOPEDIC surgeries you have had and dates:
______________________________________________
______________________________________________
______________________________________________
______________________________________________

List any other surgeries you have had and dates:
______________________________________________
______________________________________________
______________________________________________
______________________________________________

List any NON-DRUG ALLERGIES you have (ex. Latex, pollen):
______________________________________________

Has anyone in your family had any of the following medical conditions?

| | Father | Mother | Sibling | Child | Other |
|---|---|---|---|---|---|
| High Blood Pressure | ☐ | ☐ | ☐ | ☐ | ☐ |
| Heart Disease | ☐ | ☐ | ☐ | ☐ | ☐ |
| Diabetes | ☐ | ☐ | ☐ | ☐ | ☐ |
| Bleeding Problems | ☐ | ☐ | ☐ | ☐ | ☐ |
| Lung Disease | ☐ | ☐ | ☐ | ☐ | ☐ |
| Cancer | ☐ | ☐ | ☐ | ☐ | ☐ |
| What type? | | | | | |

| Smoking History: | Years of Use/ Age: | Chewing Tobacco History: | Caffeine Intake: |
|---|---|---|---|
| ☐ Never smoker<br>☐ Former smoker<br>☐ Smoking status unknown<br>☐ Current | ____________________<br>Amount:<br>____________________ | ☐ No<br>☐ Yes<br>If "YES" how much?<br>______________ | ☐ None<br>☐ Occasional<br>☐ Moderate<br>☐ Heavy |

| Do you drink alcohol? ☐Yes ☐No | Amount? | What kind? |
|---|---|---|
| Do you use drugs for recreational use? ☐Yes ☐No | Amount? | What kind? |

| Height: | Weight: | BP: | Race: ☐Black ☐White ☐Hispanic ☐Other: | Stress Level: ☐Low ☐Medium ☐High |
|---|---|---|---|---|

| Marital status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Domestic Partner ☐Separated ☐Unknown | Live alone or with others? | If children; How many? |
|---|---|---|
| Exercise Level: ☐ None ☐ Occasional ☐Moderate ☐Heavy | Sporting activities? | Seat belt used routinely? |

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

Patient Signature: ______________________________________________ Date: ______________________________

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Have YOU ever been diagnosed with any of the following? **Any "YES", Explain**

| A "TRICK" JOINT | Yes: ☐ | No: ☐ | HEPATITIS | Yes: ☐ | No: ☐ |
|---|---|---|---|---|---|
| ANEMIA | ☐ | ☐ | HERNIA | ☐ | ☐ |
| ANXIETY DISORDER | ☐ | ☐ | IRREGULAR VAGINAL BLEEDING | ☐ | ☐ |
| ARTHRITIS OR RHEUMATISM | ☐ | ☐ | KIDNEY DISEASE | ☐ | ☐ |
| ASTHMAS | ☐ | ☐ | KIDNEY STONES | ☐ | ☐ |
| BIRTH CONTROL PILLS | ☐ | ☐ | LEG OR FOOT ULCERS | ☐ | ☐ |
| BLEEDING DISORDER | ☐ | ☐ | LIVER DISEASE | ☐ | ☐ |
| BLOOD CLOTS | ☐ | ☐ | LUNG DISEASE | ☐ | ☐ |
| BLOOD TRANSFUSION | ☐ | ☐ | MENSTUAL PERIODS (DATE OF LAST): | ☐ | ☐ |
| BLOOD IN SPUTUM | ☐ | ☐ | MIGRAINES | ☐ | ☐ |
| BLOOD IN URINE | ☐ | ☐ | NERVOUS TROUBLE | ☐ | ☐ |
| BLOODY STOOLS OR BLACK TARRY STOOLS | ☐ | ☐ | NOSEBLEEDS OR SINUS TROUBLE | ☐ | ☐ |
| CHRONIC COUGH | ☐ | ☐ | OSTEOPOROSIS | ☐ | ☐ |
| CORONARY ARTERY DISEASE | ☐ | ☐ | PACEMAKER | ☐ | ☐ |
| DEPRESSION | ☐ | ☐ | PAIN OR PRESSURE IN CHEST | ☐ | ☐ |
| DIABETES | ☐ | ☐ | PAINFUL FREQUENT URINATION | ☐ | ☐ |
| DIZZINESS OR FAINTING SPELLS | ☐ | ☐ | PERIPHERAL VASCULAR DISEASE | ☐ | ☐ |
| EASY BRUISING OR BLEEDING | ☐ | ☐ | PULMONARY EMBOLISM | ☐ | ☐ |
| EPILEPSY: "FITS"; OR BLACKOUTS | ☐ | ☐ | RECENT CHANGE IN BOWEL MOVEMENTS | ☐ | ☐ |
| FREQUENT HEADACHES | ☐ | ☐ | RHEUMATOID ARTHRITIS | ☐ | ☐ |
| FREQUENT SORE THROAT | ☐ | ☐ | SEIZURES/EPILEPSY | ☐ | ☐ |
| GERD/ REFLUX | ☐ | ☐ | SHORTNESS OF BREATH | ☐ | ☐ |
| GALLBLADDER TROUBLE OR GALLSTONES | ☐ | ☐ | SLEEP APNEA | ☐ | ☐ |
| GOITER | ☐ | ☐ | TROUBLE HEARING OR FREQUENT EAR INFECTIONS | ☐ | ☐ |
| GOUT | ☐ | ☐ | TROUBLE SEEING OR PAIN IN THE EYES | ☐ | ☐ |
| HIV OR AIDS | ☐ | ☐ | TUBERCULOSIS | ☐ | ☐ |
| HAY FEVER | ☐ | ☐ | ULCERS | ☐ | ☐ |
| HEART ATTACK (MI) | ☐ | ☐ | URINARY TRACT INFECTIONS | ☐ | ☐ |
| HEART DISEASE | ☐ | ☐ | WEAKNESS OR PARALYSIS | ☐ | ☐ |
| HEART PROBLEMS | ☐ | ☐ | YELLOW JAUDANCE | ☐ | ☐ |

| HIGH BLOOD PRESSURE/ HYPERTENSION | Yes: (if "yes" EXPLAIN) ☐ | No: ☐ |
|---|---|---|
| CANCER | ☐ | ☐ |

## REVIEW OF SYSTEMS & CHIEF COMPLAINT

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## REVIEW OF SYSTEMS

Do you currently have any issues with the following?
(If "YES" circle all that apply)

Yes No **Constitutional**: fever, night sweats, weight gain weight loss, exercise intolerance
Additional notes:

Yes No **Eyes**: dry eyes, irritation, vision change
Additional notes:

Yes No **Nose**: frequent nosebleeds, nose/sinus problems
Additional notes:

Yes No **Mouth/Throat**: sore throat, bleeding gums, Snoring, dry mouth, oral abnormalities mouth ulcer, teeth abnormalities, mouth breathing
Additional notes:

Yes No **Cardiovascular**: arm pain on exertion, shortness of breath when walking, shortness of breath when lying down, palpitations, known heart murmur, light-headed on standing
Additional notes:

Yes No **Respiratory**: cough, wheezing, shortness of breath, coughing up blood, sleep apnea
Additional notes:

Yes No **Genitourinary**: urinary loss of control, difficulty urinating, increased urinary frequency, hematuria, incomplete emptying
Additional notes:

Yes No **Musculoskeletal**: muscle aches, muscle weakness, arthralgia/ joint pain, back pain, swelling in the extremities
Additional notes:

Yes No **Skin**: abnormal mole, jaundice, rash, itching, dry skin, growths/ lesions
Additional notes:

Yes No **Neurologic**: loss of consciousness, weakness, numbness, seizures, dizziness, frequent of severe headaches, migraines, restless legs
Additional notes:

Yes No **Psychiatric**: depression, sleep disturbance, restless sleep, feeling unsafe in relationship, alcohol abuse
Additional notes:

Yes No **Endocrine**: fatigue, increased thirst, hair loss, increased hair growth, cold intolerance
Additional notes:

Yes No **Hematologic/Lymphatic**: swollen glands, easy bruising, excessive bleeding
Additional notes:

Yes No **Allergic/Immunologic**: runny nose, sinus pressure, itching, hives, frequent sneezing
Additional notes:

## CURRENT PROBLEM

Please circle all that apply:

**Chief complaint**: ________________________________

**Location**: Neck Upper Back Lower Back
Shoulder Arm Elbow Forearm
Wrist Hand Finger Hip
Thigh Knee Lower Leg Foot

Right Left Bilateral

**Quality of Pain**: Intermittent Ill-defined
Constant Burning Aching
Dull Sharp Throbbing

**Pain**: Left 1 2 3 4 5 6 7 8 9 10
Right 1 2 3 4 5 6 7 8 9 10

**Onset**: Gradual Sudden without injury
Injury: ____________________________

**How long**: ________Days Weeks Months Years

**Context**: Improving Worsening No Change

**Modify Factors**:
Improved by: Rest Activity Ice/Cold Heat
Worsened by: Rest Activity Ice/Cold Heat

**Associated signs or symptoms**: _____________________
______________________________________________
______________________________________________

**Prior Evaluation**:
Family Doctor E/R Urgent Care
Other Orthopedic Surgeon

X-ray MRI CT Scan Bone Scan
Lab Test Nerve Test

**Prior Treatment**:
Over the Counter: Ibuprofen Aleve Aspirin
Tylenol Topical
Prescription Meds: Arthritis meds Narcotics
Muscle Relaxer Steroids
Physical Therapy Chiropractor Brace

How Long have you tried the above prior to treatment?

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