



OrthoMaryland  
Innovative solutions. Comprehensive care.

## Personal Medical History Information

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Reason for Visit \_\_\_\_\_

Private Physician \_\_\_\_\_

Referred By:  self  family/friend  physician  emergency room

**Conditions you have or have had in the past: (X for Yes, please leave space blank for No)**

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> AIDS                     | <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> High blood pressure  | <input type="checkbox"/> Seizures                 |
| <input type="checkbox"/> Alcoholism               | <input type="checkbox"/> Are you on insulin?        | <input type="checkbox"/> HIV positive         | <input type="checkbox"/> Sleep apnea              |
| <input type="checkbox"/> Anemia                   | <input type="checkbox"/> Do you get foot ulcers?    | <input type="checkbox"/> Irregular heartbeat  | <input type="checkbox"/> Thyroid problems         |
| <input type="checkbox"/> Arthritis                | <input type="checkbox"/> Are your kidneys affected? | <input type="checkbox"/> Kidney disease       | <input type="checkbox"/> Tuberculosis             |
| <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Are your eyes affected?    | <input type="checkbox"/> Liver disease        | <input type="checkbox"/> Ulcers                   |
| <input type="checkbox"/> Bleeding disorder        | <input type="checkbox"/> Gout                       | <input type="checkbox"/> Lung disease         | <input type="checkbox"/> Urinary tract infections |
| <input type="checkbox"/> Blood clot               | <input type="checkbox"/> Heart disease              | <input type="checkbox"/> Osteoporosis         | <input type="checkbox"/> Varicose veins           |
| <input type="checkbox"/> Bronchitis               | <input type="checkbox"/> Heart attack               | <input type="checkbox"/> Pacemaker            | <input type="checkbox"/> Venereal disease         |
| <input type="checkbox"/> Cataracts                | If yes, what year? _____                            | <input type="checkbox"/> Psychiatric problems |   |
| <input type="checkbox"/> Chemical dependency      | <input type="checkbox"/> Hepatitis                  |   |   |
| <input type="checkbox"/> Cancer (list type) _____ |   |   |   |

**Other medical problems:** (Please list any conditions you have that were not found above.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Surgery:** (List all operations, whether in-patient or ambulatory.)

Operation	Year
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

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We offer three Baltimore area locations to serve you:  
**Phone number for patients (all locations): 410-377-8900**

**Baltimore/Quarry Lake:**  
2700 Quarry Lake Drive  
Suite 300  
Baltimore, MD 21209

**Owings Mills:**  
4 Park Center Court  
Suite 102  
Owings Mills, MD 21117

**Towson/GBMC:**  
Physicians Pavilion East  
6565 North Charles Street  
Suite 504  
Towson, MD 21204

# Personal Medical History Information, continued

**Orthopaedic surgeries:** (List all orthopaedic surgeries, whether in-patient or ambulatory.)

<b>Operation</b>	<b>Year</b>
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

**Medications:** (List all medications currently taking, including over the counter medications, vitamins, herbs, etc.)

<b>Drug</b>	<b>Condition medication is prescribed for</b>	<b>Strength</b>	<b>Dose (How often)</b>
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____
7. _____	_____	_____	_____
8. _____	_____	_____	_____
9. _____	_____	_____	_____
10. _____	_____	_____	_____

**Allergies:** (List all allergies to medications and/or other items.)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Height:** \_\_\_\_ feet \_\_\_\_ inches    **Weight:** \_\_\_\_ lbs.    **Handedness:**     Right     Left     Ambidextrous

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# Personal Medical History Information, continued

**Symptoms you currently have or have had in the past year:**

*(X for Yes, please leave blank space for No)*

**General**

- Chills
- Depression
- Fever
- Loss of Weight
- Nervousness
- Sweats

**Muscle/Joint/Bone**

- Pain, weakness, numbness in:
- Arms                       Hips
  - Back                         Legs
  - Feet                          Neck
  - Hands                       Shoulders
  - Knee

**Gastrointestinal**

- Poor appetite
- Constipation
- Diarrhea
- Hemorrhoids
- Indigestion
- Rectal bleeding
- Stomach pain

**Skin**

- Scars
- Rash
- Sores that won't heal

**Genitourinary**

- Blood in the urine
- Frequent urination
- Lack of bladder control
- Painful urination

**Cardiovascular**

- Shortness of breath
- Shortness of breath with exertion
- Chest pain

**Eye, Ear, Nose, Throat**

- Vision problems (other than glasses)
- Swallowing
- Loss of hearing
- Persistent cough

**Family History:** List any medical illnesses for each member. Please make sure to indicate if you have NO SISTERS/BROTHERS OR CHILDREN or if they have NO MEDICAL PROBLEMS.

Father: \_\_\_\_\_

Mother: \_\_\_\_\_

Sisters: \_\_\_\_\_

Brothers: \_\_\_\_\_

Grandparents: \_\_\_\_\_

Children: \_\_\_\_\_

List any other diseases that occur in your family and that family member's relationship to you: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Social History:**

Please indicate whom you live with, and their relationship to you, on the line below:

\_\_\_\_\_

Do you use tobacco now? \_\_\_\_\_ In the past? \_\_\_\_\_ Type and Amount \_\_\_\_\_

Do you use alcohol? \_\_\_\_\_ Type \_\_\_\_\_ Weekly Amount \_\_\_\_\_

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## Personal Medical History Information, continued

Do you use illicit drugs? \_\_\_\_\_ Type \_\_\_\_\_ Weekly Amount \_\_\_\_\_

**Exercise History:** Describe what type of exercise you perform and how often:

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**Occupational History:** Describe the kind of work you currently perform as well as work you have performed in the past:

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If you have comments or questions that do not fit any of the above categories, please include them here:

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Patient or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed By: (Physician) \_\_\_\_\_ Date: \_\_\_\_\_

### Our physicians:

Jerome P. Reichmister, M.D.  
Larry Becker, M.D.  
William I. Smulyan, M.D.  
Robert D. Keehn, M.D.  
Mark S. Rosenthal, M.D.  
Robert Riederman, M.D.  
Steven L. Friedman, M.D.  
Ian M. Weiner, M.D.

Barry J. Waldman, M.D.  
Jon D. Koman, M.D.  
Jason Phipps Brokaw, M.D.  
David P. Buchalter, M.D.  
Peter R. Jay, M.D.  
Lisa J. Grant, M.D.  
Benjamin N. Carr, III, M.D.  
Mark A. Deitch, M.D.

### Our subspecialties:

Arthritis	Low back pain
Cartilage repair	Pain management
Foot & ankle	Physiatry
Hand, wrist & elbow	Pediatric orthopaedics
Hip replacement	Shoulder
Joint reconstruction & total replacement	Spine & neck
Knee replacement	Sports medicine