MEDICAL HISTORY FORM

Please print a copy of this form so you can fill it out and bring it with you when you come in for your consultation with Dr Myers. Please Tick the boxes as appropriate.

NAME

Age ☐ Male ☐ Female Height cm Weight kg

Are you? ☐ Right Handed ☐ Left Handed ☐ Ambidextrous (Both)

OCCUPATION

Indicate most appropriate ☐ Clerical ☐ Light Manual ☐ Heavy Manual ☐ Professional ☐ Unemployed

☐ Retired If so - What did you do previously?

Marital Status

What **SPORT** do you play?

Previously??

List your Hobbies

INJURY ASSESSMENT - If applicable. 1. Date of Injury:

2. Where did it occur?? Site of Injury Other....

3. How did it occur?? Mechanism of Injury Other

What **PROBLEMS** have you noted??? Indicate all

☐ Pain	☐ Catching	☐ Waking from Sleep	☐ Sprain
☐ Swelling / Lump	☐ Weakness	☐ Deformity	☐ Fracture
☐ Stiffness	☐ Numbness	☐ Colour change	Other
☐ Clicking	☐ Tingling	☐ Abnormal sweating	

What **TREATMENT** have you had so far???

☐ None ☐ Rest ☐ Splint ☐ Cast ☐ Pain Killers ☐ Anti-Inflammatories ☐ Injections ☐ Physio

☐ Surgery Date of Surgery Other

PAIN Assessment On a Scale of 0 - 10 how do you rate your pain?? 0 = No pain, 10 = The worst pain you could imagine eg Your leg being chopped off with a chain saw!

Pain at Best Pain when Worst

Does the Pain **WAKE** you from SLEEP?? ☐ YES ☐ NO How often do you wake / week?? / Week

What things relieve the pain??

WHat things are you unable to do?? ◯ Work Full duties ◯ Work Light Duties ◯ Drive ◯ Housework

◯ Open Jars ◯ Fine manipulation eg Buttons Other

GENERAL HEALTH Please indicate if you have or have had any of the medical conditions listed.

◯ Angina / Heart Attack
◯ Hypertension Blood pressure
◯ Diabetes
◯ Cholesterol (High)
◯ Stroke
◯ Kidney Disease
◯ Lung Problems
◯ Asthma
◯ Cancer

Type of Cancer

◯ Venous Thrombosis DVT Clotting
◯ Pulmonary Embolus Clot to lung
◯ Bleeding problems
◯ Hepatitis
◯ HIV / AIDS
◯ Reflux / Heart Burn
◯ Psoriasis
◯ Haemochromatosis
◯ Thyroid disease
◯ Recent Viral Illness

◯ Osteoarthritis
◯ Rheumatoid arthritis
◯ Gout
◯ Osteoporosis
◯ Previous fractures
◯ Polycystic Ovary Syndrome
◯ Anxiety
◯ Depression

Other

List any **OPERATIONS** you have had. ◯ Carpal Tunnel ◯ Trigger finger ◯ Joint Replacement ◯ Prostate

◯ Thyroid ◯ Gall Bladder ◯ Heart Bypass ◯ Stent ◯ Hysterectomy ◯ Spine ◯ Arthroscopy

Other

Have you had problems with operations?

Are there any conditions which run in your **Family**? ◯ Arthritis ◯ Gout ◯ Psoriasis ◯ Diabetes

◯ Dupuytrens disease Other

Please list all **ALLERGIES** ◯ Penicillin ◯ Sulphur ◯ Sticking Plaster Other

Do you **SMOKE**?? ◯ Previously How many / Day How many years have you smoked?

How many glasses of **ALCOHOL** do you drink / week? Previously more ?

What MEDICATIONS are you taking now?? ◯ Warfarin ◯ Plavix ◯ Xarelto ◯ Aspirin ◯ Zyloprim ◯ Oroxine

Other Medications

Signature _____ Date

Print Form Submit by Email