OCH ORTHOPEDIC CENTER
401 HOSPITAL ROAD
STARKVILLE, MS 39759
662-615-3741 OFFICE, 662-615-3745 FAX

Patient Name: _____

Date of Birth: _____

Marital Status: Sinlge Married Divorced Widowed Student Child

Occupation:_____

Reason for Visit: _____

Current Symptoms:_____

Please list the name and city of your **PRIMARY PHARMACY**

Name:_____ City:_____

Are you taking **ANY** medications now? (This includes Prescriptions, over the counter, and herbal medications.)

Yes No

NAME OF MEDICATION		DOSAGE	HOW OFTEN

Are you allergic to **ANY** medications? Yes No

NAME OF MEDICATION	TYPE OF REACTION

Social History

Do you use any tobacco products of any kind? Yes No How many years? _____

Approximately how much? _____ How long ago did you quit?_____

Do you consume alcohol? Yes No How many years? _____

Approximately how much? _____ How long ago did you quit?_____

Name _____ Chart# _____

Medical History

Have you ever been diagnosed with the following problems? (circle all that apply)

Cancer: Yes No If yes, what kind?_____

Liver Disease	Yes	No	Emphysema	Yes	No
Asthma	Yes	No	HIV	Yes	No
Kidney Disease	Yes	No	Seizures	Yes	No
Anemia	Yes	No	Reflux	Yes	No
Stroke	Yes	No	Ulcerative Colitis	Yes	No
COPD	Yes	No	Heart Attack	Yes	No
Sleep Apnea	Yes	No	Anxiety	Yes	No
High Cholesterol	Yes	No	Diabetes	Yes	No
High Blood Pressure	Yes	No	Hyperthyroidism	Yes	No
Heart Disease	Yes	No	Congestive Heart Failure	Yes	No

Other conditions not listed?_____

Please list all surgeries and include dates(approximate):

Procedure/Surgery	Date
_____	_____
_____	_____
_____	_____
_____	_____

Family History

Does any member of your family have problems with any of the following? If so, please list relationship to patient

	Mother		**Father**	
Heart Disease	Yes	No	Yes	No
High Blood Pressure	Yes	No	Yes	No
Asthma	Yes	No	Yes	No
Stroke	Yes	No	Yes	No
Diabetes	Yes	No	Yes	No
Cancer	Yes	No-Type_____	Yes	No_____
Deceased	Yes	No	Yes	No

Cause of Death:_____ Cause of Death_____

Patient Name _____ **Chart #** _____

REVIEW OF SYSTEMS

(please circle all the following sumptoms you have recently had)

General Health:

Fever Chills Unintenional Weight Loss Sleeping Problems
Fatigue Dizziness Weight Gain

Lung and Respiratory:

Frequent non-productive cough Frequent productive cough Shortness of Breath
Wheezing

Heart and Circulation:

Blacking out or Fainting Chest Pains Irregular Heartbeat Swelling of Ankles
Chest Discomfort Trouble Breathing on Exertion Calf or Leg Pain

GI:

Abdominal Pain Diarrhea Bloating Constipation Heartburn
Nausea Vomitting Loss of Appetite

GU:

Blood in Urine Painful urination

Skin/Nails:

Abscess Cyst Ingrown toenail Keloid Lesion Mole
Skin Tag Tumor/Mass Ulcer Wart Breast Mass/Pain

Endocrine:

Excessive hunger Excessive thirst Excessive sweating
Increase/decreased energy level Unwanted weight change

Please list any other symptoms you currently have that are not listed above

_____
_____
_____
_____
_____
_____
_____