



Main Line HealthCare  
Physician Network

# Main Line Orthopaedics & Sports Medicine

*Please answer the following questions to the best of your ability and explain all answers.*

**NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

AGE: \_\_\_\_\_ CURRENT WEIGHT: \_\_\_\_\_ CURRENT HEIGHT: \_\_\_\_\_

OCCUPATION AND WORKPLACE: \_\_\_\_\_

ARE YOU CURRENTLY WORKING: \_\_\_\_\_ IF NOT WHEN DID YOU STOP? \_\_\_\_\_

IF NOT WORKING, PLEASE EXPLAIN WHY? \_\_\_\_\_

DATE OF INJURY OR ONSET OF SYMPTOMS: \_\_\_\_\_

FAMILY DOCTOR NAME AND ADDRESS: \_\_\_\_\_

PHYSICIAN WHO SENT YOU HERE: \_\_\_\_\_

PLEASE LIST ALL PHYSICIAN SPECIALISTS THAT YOU SEE: \_\_\_\_\_

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

REASON FOR VISIT: (Please explain **which side**, **how** and **when** things began, describe your symptoms and severity, **what** makes your symptoms better or worse, are things getting any better or worse, any **tests** or **treatment** you may have had for this problem, etc.)

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

PLEASE LIST ALL MEDICAL PROBLEMS WITH THEIR CORRESPONDING MEDICATIONS (ex: hypertension, diabetes, etc.)

**MEDICATIONS:**

**ASSOCIATED MEDICAL PROBLEM:**

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____



# Main Line Orthopaedics & Sports Medicine

**PAGE 2 NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

PLEASE LIST ALLERGIES TO MEDICATIONS: (DESCRIBE REACTION FOR EACH):

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ARE YOU ALLERGIC TO TAKE, IODINE, OR LATEX? \_\_\_\_\_

PLEASE LIST ALL MAJOR SURGERIES YOU HAVE HAD, INCLUDING DATES AND SIDE (LEFT OR RIGHT):

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DO YOU SMOKE? \_\_\_\_ YES \_\_\_\_ NO HOW MANY PACKS PER DAY? \_\_\_\_\_

HAVE YOU EVER SMOKED? (HOW MUCH AND FOR HOW LONG) \_\_\_\_\_

IF YES, WHEN DID YOU QUIT? \_\_\_\_\_

DO YOU DRINK? \_\_\_\_ YES \_\_\_\_ NO HOW MUCH? \_\_\_\_\_

HAVE YOU EVER HAD A DRUG OR ALCOHOL PROBLEM? \_\_\_\_\_

PLEASE LIST ALL MAJOR DISEASES THAT RUN IN YOUR FAMILY:

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## **REVIEW OF SYSTEMS**

*Please explain all YES answers.*

Have you ever had a problem taking aspirin, Motrin, or other arthritis type medication?

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Have you had a history of recent fevers, sweats, chills, or weight loss?

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Have you had any problems with your heart or blood pressure?

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PAGE 3 NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

**REVIEW OF SYSTEMS - Continued**

*Please explain all YES answers.*

Have you had any problems breathing or lung problems (ex: asthma, emphysema, cough, etc)?

Have you had any problems with digestion or bowel problems?

Have you had any problems with kidney or bladder function (ex: kidney stones, problems with urination)?

Have you had any problems with other joint or muscles? (arthritis, gout, osteoporosis, etc)?

Have you had any problems with your skin? (rashes, etc)?

Have you had any neurological problems (ex: stroke, seizure, dizziness, nerve, or headache)?

Have you had any endocrine (hormonal) problems such as diabetes (sugar, thyroid, etc)?

Have you had any problems with anemia, bleeding, or other blood problems?

Do you have a history of intestinal bleeding?

Do you have any liver problems (hepatitis, jaundice, etc)?

Have you had any problems with your eyes?

Have you had any problems with your ears, nose, throat, or mouth?

Please list any other health problems not already mentioned

\_\_\_\_\_  
YOUR SIGNATURE

\_\_\_\_\_  
PHYSICIAN SIGNATURE