

Today's Date \_\_\_\_\_

**WARDELL ORTHOPAEDICS, P.C.**  
Patient Medical History

**Patient Information**

Name \_\_\_\_\_  
Last First Middle  
AGE \_\_\_\_\_ Date of Birth \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

**Office Use Only**

Patient ID  
(Greenway #) \_\_\_\_\_  
Other ID  
(W.O. #) \_\_\_\_\_

**Past Medical History**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Bleeding Disorder          | <input type="checkbox"/> Hypertension/High Blood Pressure | <input type="checkbox"/> Sleep Apnea                 |
| <input type="checkbox"/> Cancer                     | <input type="checkbox"/> Osteopenia                       | <input type="checkbox"/> Stomach/Intestinal Problems |
| <input type="checkbox"/> Deep Vein Thrombosis (DVT) | <input type="checkbox"/> Osteoporosis                     | <input type="checkbox"/> Other _____                 |
| <input type="checkbox"/> Diabetes Type 1            | <input type="checkbox"/> Pulmonary Embolism (PE)          | _____  |
| <input type="checkbox"/> Diabetes Type 2            | <input type="checkbox"/> Pulmonary/Lung Disease           | _____  |
| <input type="checkbox"/> Heart Disease              |   | _____  |

**Past Surgical History**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Anesthesia Complications | <input type="checkbox"/> Gastric Bypass      | <input type="checkbox"/> Total Hip Replacement      |
| <input type="checkbox"/> Appendectomy             | <input type="checkbox"/> Hysterectomy        | <input type="checkbox"/> Total Knee Replacement     |
| <input type="checkbox"/> Breast Surgery           | <input type="checkbox"/> Pacemaker Insertion | <input type="checkbox"/> Total Shoulder Replacement |
| <input type="checkbox"/> C-Section                | <input type="checkbox"/> Spinal Fusion       | <input type="checkbox"/> Tubal Ligation             |
| <input type="checkbox"/> Cardiac Stent Placement  | <input type="checkbox"/> Thyroidectomy       | <input type="checkbox"/> Vasectomy                  |
| <input type="checkbox"/> Cholecystectomy          | <input type="checkbox"/> Tonsilectomy        | <input type="checkbox"/> Other _____                |

**Allergy List**

- |   |                                     |                                     |                                      |
|---|-------------------------------------|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> **No Known Allergy | <input type="checkbox"/> Latex      | <input type="checkbox"/> Propofol   | <input type="checkbox"/> Tramadol    |
| <input type="checkbox"/> Amoxiciliin        | <input type="checkbox"/> Lisinopril | <input type="checkbox"/> Prozac     | <input type="checkbox"/> Tylox       |
| <input type="checkbox"/> Augmentin          | <input type="checkbox"/> Neurotin   | <input type="checkbox"/> Roxicet    | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cardizem           | <input type="checkbox"/> Norco      | <input type="checkbox"/> Shell Fish | _____                                |
| <input type="checkbox"/> Egg                | <input type="checkbox"/> Pamelor    | <input type="checkbox"/> Sulfa      | _____                                |
| <input type="checkbox"/> Hydrocodone        | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Topamax    | _____                                |

**Social History**

- ☐ Tobacco  
Current Smoker? ☐ Yes ☐ No If Yes, how much per day? \_\_\_\_\_  
Former Smoker? ☐ Yes ☐ No If Yes, how much and for how long? \_\_\_\_\_

**Current Medications**

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

**WARDELL ORTHOPAEDICS, P.C.**

Reason for Visit

Today's Date

**Patient Identification**

Name \_\_\_\_\_  
Last First Middle  
AGE \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Office Use Only**

Patient ID  
(Greenway #) \_\_\_\_\_  
Other ID  
(W.O. #) \_\_\_\_\_  
Resource \_\_\_\_\_  
Recep. Initials \_\_\_\_\_

Referring Physician \_\_\_\_\_

Please provide full name and phone #, if available. \_\_\_\_\_

Date of Symptoms \_\_\_\_\_

Date of Injury \_\_\_\_\_

Family Physician \_\_\_\_\_ Time of Injury \_\_\_\_\_ am / pm

Chief Complaints (Body Parts) \_\_\_\_\_

Location of injury (Street, City and State) \_\_\_\_\_

Type of injury (i.e., auto, pedestrian, bicycle, etc.) \_\_\_\_\_

Details of Accident/Injury and/or History of Present Symptoms (i.e., pain, swelling, numbness, etc.)

Seen in the Urgent Care Center? ☐ Yes ☐ No Where? \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_ am / pmSeen in the Emergency Room? ☐ Yes ☐ No Where? \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_ am / pmX-Rays taken? ☐ Yes ☐ No Where? \_\_\_\_\_ Brought films? ☐ Yes ☐ No**On-The-Job Injury?** ☐ Yes ☐ No **Reported to Employer?** ☐ Yes ☐ No To Whom? \_\_\_\_\_Have you ever been seen by Dr. Wardell or Dr. Harrell or any other Doctor at W.O? ☐ Yes ☐ No When? \_\_\_\_\_**DO NOT WRITE BELOW THIS POINT — OFFICE USE ONLY****MMC On Service?** ☐ Yes ☐ No Seen by W.O. Physician? ☐ Yes ☐ No Doctor \_\_\_\_\_ Date Seen \_\_\_\_\_**Characteristics** \_\_\_\_\_**Previous problems with above area** \_\_\_\_\_