MedStar Orthopaedics

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Name_____ Date of Birth _____

Address: _____ Phone #: _____

The Patient Portal is available to access your medical records and communicate with our physicians and staff. To register please log on to mymedstar.org

Email Address: _____

Would you like us to forward your office notes to your Primary Care Physician? ☐ No ☐ Yes

Primary Care Physician: Name_____ Phone #:_____

Date of injury or onset of illness: _____

Is your visit today related to any of the following? ☐ Automobile Accident ☐ Workers compensation ☐ Liability

After your visit, would you like us to discuss your healthcare needs with a caregiver, family member, or significant other?

☐ Yes ☐ No If yes, Name: _____ Phone #: _____

May we discuss the following (check ALL that apply):

☐ Appointments ☐ Billing Issues ☐ Medications ☐ All healthcare information

Medical History

Are you right handed? ☐ Are you left handed? ☐

Occupation:_____

Do you bleed easily? ☐ No ☐ Yes

Heart Disease ☐	Tuberculosis ☐
High/Low Blood Pressure ☐	HIV ☐
Stroke ☐	Urinary Infection ☐
Kidney Trouble ☐	Diabetes ☐
Thyroid Trouble ☐	Arthritis ☐
Liver Trouble ☐	Gout ☐
Hepatitis ☐	Asthma ☐
Stomach Ulcers ☐	Epilepsy ☐

List any other medical conditions _____

Name: _____

Date of Birth: _____

Are you experiencing any of the following symptoms today? ☐ Yes ☐ No

If yes, please check all that apply.

- o Headache
- o Vision
- o Hearing
- o Swallowing
- o Chest Pain
- o Shortness of Breath
- o Diarrhea
- o Constipation
- o Poor Circulation
- o Blood in Stool

List all surgeries and include the date of procedure

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

Environmental/Functional/Falls:

Do you currently use an assistive device? ☐ No ☐ Yes ☐ Walker ☐ Cane ☐ Wheelchair

Is there a history of falling in the last two years? ☐ No ☐ Yes

Do you believe you may be at risk for falling? ☐ No ☐ Yes

Advanced Directives:

Do you have an advance directive/living will? ☐ No ☐ Yes

If NO, would you like more information about advanced directives? ☐ No ☐ Yes

Print Name: _____

Signature: _____

Date: _____

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_____

_____ Date: _____

Relationship to patient:_____

Staff /Reviewer signature:_____Date: _____

❑ Requested patient bring in medications or call back with complete medication information _____ _____
Date Initials

Patient Medication Summary

ALLERGIES	**Type of Reaction (what happens to you)**

minerals, over-the-counter medications, or herbal supplements you are taking.		you take it	(strength/dose)	it? (By mouth, injection, etc)	(approx year if unknown)
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					

***Note: All information on medications & allergies is obtained per the patient.