



Ortho Montana PSC

Past Medical History/ ROS Form and Social Family History form

NAME _____ PATIENT # _____ DATE _____
 DOB _____ AGE _____ PRIMARY CARE PROVIDER _____
 REFERRING DR. _____

Current Medications (include over the counter and herbal).

MEDICATION	Dose	Frequency	MEDICATION	Dose	Frequency
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

SOCIAL HISTORY: Do you use alcohol? how long / much _____
 Do you use Caffeine? how long / how much _____
 Do you use tobacco? Yes / No Cigs / Chew How long? _____ How much per day? _____
 Marital Status: _____ Do you have children Y / N ages: _____
 Occupation _____ Hobbies _____

FAMILY HISTORY REVIEW (please list relationship)

Alcoholism _____ Cancer _____ Mental Illness _____
 Arthritis _____ Diabetes _____ Reaction to anesthesia _____
 Asthma/COPD _____ Heart Disease _____ Stroke _____
 Bleeding Disorder _____ High Blood Pressure _____ Other _____

Have you have been diagnosed with any of the following: (If there is more info, please use the back of this sheet.)

AIDS/HIV	Y/N	Hepatitis	Y/N	Stomach Ulcers	Y/N
Anemia	Y/N	High Blood Pressure	Y/N	Spinal cord Stimulator	Y/N
Asthma	Y/N	High Cholesterol	Y/N	Stroke	Y/N
Cancer	Y/N	Hypothyroidism	Y/N	Substance Abuse	Y/N
Congestive Heart Failure	Y/N	Kidney Disease	Y/N	Surgical Site Infection	Y/N
COPD/Emphysema	Y/N	Obesity	Y/N	Tuberculosis	Y/N
Coronary Artery Disease	Y/N	Osteoarthritis	Y/N	Urinary Tract Infections	Y/N
Deep Venous Thrombosis	Y/N	Osteoporosis	Y/N	Women- Pregnant now	Y/N
Depression	Y/N	Pacemaker	Y/N	– Menopause	Y/N
Diabetes	Y/N	Peripheral Vascular Disease	Y/N	Men- Enlarged Prostate	Y/N
Fibromyalgia	Y/N	Psychiatric illness	Y/N	Other _____	
Heart Arrhythmias	Y/N	Rheumatoid Arthritis	Y/N	Other _____	
Heart Attack	Y/N	Seizures	Y/N		
Heart Stent	Y/N	Sleep Apnea/CPAP	Y/N		

ALLERGIES (Penicillin, Latex, Medications, etc.) None/Yes List: _____

When was your last tetanus shot? _____

Previous surgeries or hospital admissions:

Are you currently having or have you had problems with:

Abdominal pain	Y / N	Fainting	Y / N
Allergies (environmental) (food)	Y / N	Headaches	Y / N
Bleeding problems	Y / N	Intolerance to heat or cold	Y / N
Blood in stool	Y / N	Incontinence	Y / N
Blurred vision	Y / N	Loss of sleep	Y / N
Bowel changes	Y / N	Lymphadenopathy	Y / N
Burning with urination	Y / N	Mental status changes	Y / N
Chest Pain	Y / N	Muscle aches (abnormal)	Y / N
Circulation	Y / N	Neck swelling	Y / N
Constipation	Y / N	Night pain	Y / N
Cough (productive)	Y / N	Night sweats	Y / N
Coughing up blood	Y / N	Pain with urination	Y / N
Diarrhea	Y / N	Palmar erythema	Y / N
Dizziness	Y / N	Palpitations	Y / N
Difficulty Breathing	Y / N	Skin Rash or Lesions	Y / N
Difficulty swallowing	Y / N	Unexplained weigh loss/gain	Y / N
Dyspepsia	Y / N	Unexplained fever, chills	Y / N
Edema	Y / N	Urethral discharge	Y / N
Excessive thirst	Y / N	Urinary frequency	Y / N
Eye prominence	Y / N	Wheezing	Y / N

Patient Signature

Date

Notes:

Vitals:

Ht _____ Wt _____ BP _____ Pulse _____