DAOUK ORTHOPAEDICS™
GET BACK YOUR ACTIVE LIFE

Daouk Orthopaedics
7350 Sandlake Commons Blvd
Suite 1102
Orlando FL, 32819
P: 407-355-7478
F:407-3542431

MEDICAL HISTORY FORM

D.O.B.	
S.S.#	
Age	
Gender:	☐ Male ☐ Female
Marital Status:	☐ S ☐ M ☐ D ☐ W

PLEASE PRINT ALL INFORMATION

NAME:

Referred here by: (circle one) self family friend doctor attorney

Name of Person / Physician making referral:

Primary Care Physician/Family Doctor:

Describe the reason for your visit:

Body part to be examined: (circle one) Right Left Both

How did your symptoms/injury begin? (describe in detail)

Approximate date symptoms began or date of injury: New or Old Injury (circle one)

On a scale of 1 - 10 (10 being most severe) circle # that best describes your pain: 1 2 3 4 5 6 7 8 9 10

Resulting from: (circle which applies) Sports Accident Work Related Involving Litigation

Are symptoms: constant intermittent worsening improving unchanged

Circle all that apply: pain stiffness swelling instability weakness numbness/tingling

What makes symptoms worse?

What makes symptoms better?

What previous or formal treatment have you had for this problem? (Medications, therapy, surgery, injections)

PAST SURGICAL HISTORY

Previous Type of Operation	Year	Physician Notes (Office Use Only)
1.		
2.		
3.		
4.		
5.		

Any previous fractures? ☐ Yes ☐ No Where?

DRUG ALLERGIES: Do you have any drug allergies: (circle one) Yes No

If yes, name the drug and describe the reaction, please be specific. (Example: rash, nausea, etc.)

CURRENT MEDS: (List any medications you are taking at this time. Include such items as aspirin, vitamins, laxatives, calcium, etc.)

NAME OF DRUG	Dose (strength and number of pills per day)	NAME OF DRUG	Dose (strength and number of pills per day)
1.		9.	
2.		10.	
3.		11.	
4.		12.	
5.		13.	
6.		14.	
7.		15.	
8.		16.	

— PLEASE TURN OVER AND COMPLETE MEDICAL HISTORY —

MEDICAL HISTORY / REVIEW OF SYSTEMS

Please check if you have a history of any of the following:	YES	NO		YES	NO
GENERAL			**CARDIOVASCULAR**		
Are you currently pregnant?			Chest Pain/Angina		
Diabetes			Heart Attack/Myocardial Infarction		
Stroke			Palpitations		
Kidney Disease			High Blood Pressure / Hypertension		
Ulcers			Shortness of Breath		
Asthma or Lung Disease			Swelling of Lower Extremities		
Cancer: Type?			**HEMATOLOGIC**		
Fatigue			Anemia		
Weakness			Blood Clots		
Fevers			Bleeding Tendency		
Skin problems/disorders: Type?			Easily Bruised		
Rheumatic Fever			Circulatory Problems		
Tuberculosis			Currently on Blood Thinners		
Recent weight gain/loss: (circle one) How much?			If yes, what type?		
BLOODBORNE PATHOGENS			Phlebitis		
HIV / AIDS			**MUSCULOSKELETAL**		
Hepatitis			Joint Pain		
Other			Joint Swelling		
SITES OF INFECTION			Muscle Weakness		
Urinary			Muscle Tenderness		
Dental			Morning Stiffness		
Other			Arthritis / Osteoarthritis		
NEUROLOGICAL			Rheumatoid Arthritis Bunions		
Headaches			Osteoporosis		
Dizziness			Bone / Joint Infections		
Fainting			Gout		
Memory Loss			**PSYCHOLOGICAL**		
Loss of Consciousness			Depression		
Muscle Spasms			Anxiety Disorder		
Numbness or Tingling of Hands/Feet			Other		
Blindness or Trouble Seeing					
Deafness or Trouble Hearing					
Seizures					

Other Illnesses or diseases which are not listed? Please describe:

FAMILY HISTORY

Please check if any of your family (parents, brothers, sisters, grandparents) have a history of any of the following:

	YES	NO		YES	NO
Diabetes (sugar)			Abnormal Bleeding Tendencies		
Heart Disease			Rheumatoid Arthritis		
Anesthetic Complications			Osteoarthritis		
Cancer: Type?			Gout		

SOCIAL HISTORY

What is your approximate weight? lbs. Height Ft. in.

Occupation: Job Duties:

Are you (circle one) right handed left handed

Do you currently smoke? ☐ Yes ☐ No
If yes or in past, # packs per day? _____ # of years? _____

Do you consume alcohol? ☐ Yes ☐ No If so, how many drinks per week?
Is there a history of abuse? ☐ Yes ☐ No

Have you ever had a problem with drugs? ☐ Yes ☐ No

Do you participate in recreational drugs? ☐ Yes ☐ No
If yes, or in past, list type and amount.

Please list all sports & hobbies you are involved in:

I, as the patient, state the information is correct and accurate to the best of my knowledge.

Patient Signature: _____ **Date:** _____