L.D. Jennings, M.D.
Board Certified Orthopaedic Surgery
Board Certified Sports Medicine

General Medical History Name: ______________________________

Year Illnesses

_____ ☐ Heart trouble ☐ Angina ☐ Heart Attack ☐ Heart Failure ☐ Heart Murmur
☐ Valve Disease Other______________________________

_____ ☐ High Blood Pressure
_____ ☐ Stroke
_____ ☐ Ulcers: ☐ Stomach ☐ Duodenal ☐ Colon
_____ ☐ Diabetes (high blood sugar)
_____ ☐ Liver Disease ☐ Hepatitis Type A ☐ Hepatitis Type B ☐ Hepatitis Type C ☐ Cirrhosis
☐ Other______________________________
_____ ☐ Kidney Disease ☐ Stones ☐ Infections
☐ Other______________________________
_____ ☐ Lung Disease ☐ Emphysema ☐ TB ☐ Chronic Bronchitis ☐ Cancer
☐ Frequent Pneumonia ☐ Asthma ☐ Other______________________________
_____ ☐ Blood Disorders ☐ Anemia ☐ Leukemia ☐ Bleeding Tendency
☐ Other______________________________
_____ ☐ Eye Disease ☐ Glaucoma ☐ Other______________________________
_____ ☐ Arthritis ☐ Degenerative ☐ Rheumatoid ☐ Gout ☐ Other______________
_____ ☐ Cancer ☐ Type______________________________
_____ ☐ Psychological ☐ Depression ☐ Psychosis ☐ Other______________________________
☐ NO MAJOR ILLNESSES

Surgeries (Other than back or neck)

Year		Year	
_____	☐ Tonsillectomy	_____	☐ Hysterectomy
_____	☐ Appendectomy	_____	☐ Prostate Operation
_____	☐ Gall Bladder	_____	☐ Biopsy
_____	☐ Hernia Repair	_____	☐ Fractures
_____	☐ Vasectomy (males)	_____	☐ Other______________________________

Major Injuries

Auto or cycle accidents, etc. please describe______________________________
____

☐ NO MAJOR INJURIES

Hospitalizations

Explain: ______________________________
____

Ladies-menstrual history

☐ My periods are normal for me ☐ I have been pregnant____times ____Still born
☐ I am Menopausal Post-menopausal ☐ I have had____vaginal deliveries ____c-sections
☐ Problems with deliveries & pregnancies List: ______________________________

Childhood diseases

☐ Rheumatic Fever ☐ Other (major only) ______________________________
☐ Nothing Unusual ______________________________

Medications (give names and doses)

☐ Aspirin ☐ Tylenol ☐ For other medical problems: ______________________________
☐ Sleep meds: ______________________________ ______________________________
☐ Anti-inflammatories______________________________ ☐ Pain meds: ______________________________
☐ Muscle relaxants: ______________________________

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Allergies (please circle reaction)

☐ Penicillin	rash	breathing problems	required hospitalization	nausea/vomiting
☐ Sulfa	rash	breathing problems	required hospitalization	nausea/vomiting
☐ Keflex	rash	breathing problems	required hospitalization	nausea/vomiting
☐ Codeine	rash	breathing problems	required hospitalization	nausea/vomiting
☐ Other_______	rash	breathing problems	required hospitalization	nausea/vomiting
☐ None				

Family Medical History

Mother: ☐ Alive and well-age______ ☐ Alive but suffers with________________________________Age_____
☐ Deceased: cause____ Age at death_____

Father: ☐ Alive and well-age______ ☐ Alive but suffers with ________________________________Age_____
☐ Deceased: cause____ Age at death_____

I have ______ living brothers/sisters; ______ deceased brothers/sisters: cause_______________________________

Members of my family (brothers, sisters, grandparents, aunts, uncles) suffer with the following:

☐ Stroke ☐ High blood pressure ☐ Cancer: type_____________________________
☐ Diabetes ☐ Heart Trouble ☐ Lung disease ☐ Back problems
☐ Arthritis ☐ Other________________________________ ☐ Don't know

Social History

☐ Married ☐ Separated ☐ Divorced ☐ Widow/widower ☐ Single: No. of children: at home_____ away_____
☐ I work as a ____
☐ I am retired from____
☐ I live with my children or other relatives. Explain____
☐ I drink ☐ beer ☐ wine ☐ "hard" drinks ☐ none
☐ Daily ☐ socially ☐ I consider myself to drink too much
☐ Others think I drink too much
☐ I smoke ☐ cigarettes ☐ pipe ☐ cigars _____packs/day for ______years
My recreational activities include ☐ jogging ☐ bicycling ☐ sports (list_____________________________________)

Review of Systems

Do you have problems other than neck or back?

☐ Eyes ☐ Ears ☐ Nose ☐ Throat
Explain____
☐ Skin, moles, spots or sores that is unusual. Explain____
☐ Unusual lumps or bumps under skin like large lymph nodes. Explain____
☐ Trouble breathing: ☐ Short of breath ☐ Cough ☐ Pain with breathing ☐ Other__________________________
☐ Chest pain/discomfort ☐ Sharp ☐ Aching ☐ Arm discomfort along with chest discomfort
☐ When under stress ☐ with activity ☐ after meals ☐ Other__________________________________
☐ Trouble with stomach or bowels ☐ Nausea/vomiting ☐ Stomach pain ☐ Diarrhea ☐ Constipation
☐ Bleeding in bowel movements ☐ Black/tarry stools ☐ Other____
☐ Trouble with legs ☐ Fatigue with walking/relieved by rest ☐ Other_________________________________
☐ Trouble with nerves ☐ Anxious/fearful ☐ I feel down/depressed

Ladies

☐ Problems with menstrual periods ☐ vaginal bleeding after menopause ☐ vaginal discharge
☐ Other problems you need to discuss with a doctor

Men

☐ Problems with sexual function ☐ Discharge ☐ other problem you need to discuss with a doctor