Dr. Christopher Mileto
St. Charles Orthopedics

General Medical History

Please fill out completely

Name: ____________________________ DOB: ___________________________ Age: _____ Today's Date: ____________
Phone Number: ____________________ PMD: ___________________________ Pharmacy: ___________________________
Were you referred by anyone? ____

ALLERGIES

Medication: ___________________________________ Specify Reaction: _______________________________________
Food: ___________________________________ Specify Reaction: _______________________________________
Other: ___________________________________ Specify Reaction: _______________________________________

PAST MEDICAL HISTORY

No Medical Problems

CARDIOVASCULAR:	Hypertension	Cholesterol	Heart Attack	Other: ______________________________
PULMONARY:	Pneumonia	Asthma / COPD	Emphysema	Other: ______________________________
GASTROINTESTINAL:	GERD Ulcers	Pancreatitis	Colitis	Other: ______________________________
NERVOUS SYSTEM:	Stroke	Parkinson's	Dementia	Other: ______________________________
RENAL SYSTEM:	Kidney failure	Dialysis	Kidney Stone	Other: ______________________________
ENDOCRINE SYSTEM:	Diabetes Type 1	Diabetes Type 2	Thyroid disease	Other: ______________________________
INFECTIOUS DISEASE:	HIV Hepatitis B / C	Tuberculosis	MRSA	Other: ______________________________
MUSCULOSKELETAL:	Osteoarthritis	Rheumatoid	Psoriasis	Other: ______________________________
HEMATOLOGIC:	Hemophilia	DVT / PE	Anemia	Other: ______________________________
PSYCHIATRIC:	Depression	Anxiety	Substance Abuse	Other: ______________________________

OTHER:
____

PLEASE SPECIFY OR EXPLAIN ANY CONDITIONS ABOVE (IF APPROPRIATE):
____
____
____

PAST SURGICAL HISTORY

List all previous surgeries: ____
____
____

MEDICATIONS

List all current medications (including over the counter medications and supplements):
____
____
____

FAMILY HISTORY

List any chronic conditions of which you are aware.
GRANDPARENTS: ____
PARENTS: ____
SIBLINGS: ____
CHILDREN: ____

SOCIAL HISTORY

Occupation: ____
Work Status: Full Time Part Time Unemployed Retired
Living Arrangements: Live Alone Live with family / friends Assisted living Other: ______________________
Do you have a special diet? Yes No If yes, please specify. ____
Do you exercise/play sports? Yes No If yes, please specify. ____
Do you smoke? Yes No Quit If yes, how much? ____
Do you drink? Yes No If yes, how much? ____
Do you use drugs? Yes No If yes, please specify. ____

Patient Signature: ___________________________Date: ____________________ Reviewed by: ____________________

Dr. Christopher Mileto
St. Charles Orthopedics

New Complaint Form

Please fill out completely

Name: ______________________________ DOB: __________________ Today's Date: ___________________

CHIEF COMPLAINT

What is the reason for today's visit? ____

HISTORY OF PRESENT ILLNESS

Where is your pain? ____

When did the pain begin? (Date or approximate duration): ____

Was your pain the result of an injury? YES NO

If yes, please specify: ____

Is this injury for worker's compensation? YES NO

What is your current work status? Full Duty Light Duty Not working Retired

How would you describe your pain or symptoms? Mild Moderate Severe

When do you have pain?

At all times With activity Intermittently Worse in the morning Worse at night

Is there anything specific that makes your pain worse? ____

Do you or did you have any of the following symptoms related to this complaint?

Swelling Bruising Stiffness Weakness Instability Numbness Radiation of pain

Other: ____

Have you had any of the following treatments for this condition? Specify where appropriate.

None

Rest Ice Compression Elevation Heat

Physical therapy Acupuncture Chiropractor

Modification of activity: ____

Medication: ____

Brace or cast: ____

Injection(s): ____ Date of last injection: ____________________

Surgery: ____ Date of surgery: _________________________

Other: ____

Were any of the above treatments effective? Please specify:

YES NO ____

Is there any other comment regarding your condition? ____

REVIEW OF SYMPTOMS

Have you recently or are you currently experiencing any of the following symptoms?

CONSTITUTIONAL:	Fevers	Chills	Feeling ill	Feeling tired		N/A
PULMONARY:	Cough	Blood in sputum	Shortness of breath			N/A
CARDIOVASCULAR	Chest pain	Leg swelling	Leg cramping	Palpitations		N/A
GASTRO-INTESTINAL:	Incontinence	Constipation	Abdominal pain	Heartburn		N/A
GENITO-URINARY:	Incontinence	Difficulty voiding	Burning	Increased Frequency		N/A
HEMATOLOGY:	Excessive bleeding	Easy bruising	Blood clots	Leg swelling		N/A
NEUROLOGICAL:	Weakness	Numbness	Seizures	Balance problems		N/A
ENDOCRINE:	Weight gain	Weight loss	Excessive Thirst	Excessive Hunger		N/A
MENTAL HEALTH:	Depression	Anxiety	Substance Abuse			N/A
DERMATOLOGIC:	Healing problems	Rashes	Redness	Ulcers	Skin Changes	N/A
ALLERGIC / IMMUNOLOGIC:	Hives	Throat closing	Generalized Swelling			N/A
MUSCULOSKELETAL:	Swelling	Stiffness	Pain			N/A

Specify Location (other than the reason for today's visit): ______________________________________

Patient Signature: __________________________Date: ____________________ Reviewed by: ____________________