

Orthopaedics

Medical History Form - Please Complete all Sections of this Form

Name: _____ **Date of Birth:** _____ **Age:** _____

Occupation: _____

Physician who sent you to us: _____

Family Doctor: _____

What problem are you being treated for today? _____

Have you been treated by another. physician for this problem? yes no **Who?** _____

Were x-rays taken? yes no **Where were the x-rays done?** _____ **When?** _____

Allergies: _____

Current Medications: _____

Past/Present Medical Problems: _____

Past Surgeries (type and year performed): _____

Past Orthopaedic Surgeries: _____

Family Medical History:

Mother: living deceased Age (now or at death) _____ Cause of death:

Father: living deceased Age (now or at death) _____ Cause of death:

Circle any known illness that has occurred in your immediate family

- | | | | | |
|--------------------|-----------|---------------|----------------|---------------------|
| Cancer | Diabetes | Epilepsy | Heart Problems | High Blood Pressure |
| Strokes | Seizures | Arthritis | Asthma | Tuberculosis |
| Anesthesia Problem | COPD | Heart Disease | Kidney Disease | Anesthesia Problem |
| Alzheimer's | Back Pain | | | |

Other:

Personal Social History:

Yes No Have you regularly smoked? Packs per day _____ How many years? _____

Yes No Do you drink alcohol? (circle) Occasionally Socially Regularly Past Abuse

Marital Status (circle one): Married Single Widowed Separated Divorced

of children _____ and their present health status _____

Review of Systems (Circle problems with any of the following)

Yes No **Head, Ears and Eyes:** Do you currently have cataracts, glaucoma, glasses, contacts, hearing aids, or experiencing any hearing loss or ringing in your ears?

Yes No **Nose, Sinuses, Throat, and Mouth:** Do you currently have any problems with your ears, nose or throat? Do you currently experience sleep apnea?

- Yes No **Skin:** Do you currently have herpes simplex, psoriasis, rashes, skin color changes or skin infections?
- Yes No **Breast:** Do you have breast cancer, benign growths, or any other symptoms pertaining to your breasts?
- Yes No **Cardiovascular:** Do you currently have any cardiovascular symptoms, such as chest pain, palpitation, lightheadedness, syncope, murmurs, or high blood pressure, high cholesterol, stents, bypass surgery, etc?
- Yes No **Respiratory:** Do you currently have asthma, bronchitis, chest pain, emphysema, COPD, shortness of breath, tuberculosis, or a productive cough, etc?
- Yes No **Gastrointestinal:** Do you currently have any gastrointestinal systems, such as cirrhosis, Crohns disease, diverticulitis, Hepatitis A, B, or C, hiatal hernia, pancreatitis, reflux, vomiting, ulcerative colitis, ulcers, diarrhea, constipation, rectal bleeding, hematochesia, etc?
- Yes No **Genitourinary:** Do you currently have any genito-urinary complaints, such as blood in urine, frequency, urgency, hesitancy, incontinence, kidney stones, etc? Do you currently undergo dialysis? Have you had the loss of a kidney or kidney transplant?
- Yes No **Gynecological:** Do you currently have any gynecological complaints, such as vaginal bleeding, discharge, pain, etc? Are you currently pregnant? If so, how many months pregnant?
- Yes No **Musculoskeletal:** Do you currently have any past or present problems related to the musculoskeletal system such as bone cancer, osteoporosis, lupus, rheumatoid arthritis, or degenerative joint disease?
- Yes No **Neurological/Psychiatric:** Do you currently have any problems related to the central nervous system, such as Alzheimer's, epilepsy, brain aneurysm, brain surgery, depression or anxiety, multiple sclerosis, paralysis, Parkinson's, Polio, seizures, stroke or stroke residual, etc?
- Yes No **Hematologic and Lymphatic:** Do you currently have any problems with bruising, bleeding gums, adenopathy, blood transfusion, or anemia?
- Yes No **Vascular:** Do you current have any problems with blood clots, hemophilia, varicose veins, pulmonary embolus, sickle cell disease?
- Yes No **Endocrine:** Do you currently have any problems with diabetes, heat or cold intolerance, thyroid problems, hypercalcemia, polyuria, polydipsia, abnormal hair growth or loss, or skin changes?

Yes No **Allergic Immunologic:** Do you currently have any problems with the allergic or immunologic organ systems?

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

Signature

Date