



**Medical History**

Do you have any allergies? Yes No

List each allergy and reaction: \_\_\_\_\_  
\_\_\_\_\_

List all medications including over the counter medications: \_\_\_\_\_  
\_\_\_\_\_

Do you smoke? Yes No How Often? \_\_\_\_\_ Do you drink? Yes No How Often? \_\_\_\_\_

Do you have any of the following medical conditions? (please check all applicable below)

- ANEMIA/BLOOD DISORDERS       GOUT       KIDNEY PROBLEMS
- ARTHRITIS       HEART DISEASE/HEART ATTACK       LUNG DISEASE
- ASTHMA       HIGH BLOOD PRESSURE       STOMACH PROBLEMS, GASTROINTESTINAL
- CANCER – what type? \_\_\_\_\_       THYROID PROBLEMS
- DIABETES – are you insulin-dependent? Yes No
- EPILEPSY/SEIZURE DISORDER PROBLEMS OR ULCERS
- OTHER \_\_\_\_\_

Is there a family history for any of the above medical condition(s)  
(mother, father, siblings, and/or grandparents)? Yes No

Please identify which medical condition(s) and which family member(s): \_\_\_\_\_  
\_\_\_\_\_

Did you ever have minor or major surgery? Yes No

What type(s) or surgery did you have? \_\_\_\_\_

**General Patient Information**

**YOUR MARITAL STATUS (please circle below)**

SINGLE      MARRIED      SEPARATED      DIVORCED      WIDOWED

Do you have children? Yes No How many? ( ) Are you pregnant? Yes No

Who is your Primary Care Physician (PCP) or Referring Physician?

Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ -- \_\_\_\_\_

Phone(\_\_\_\_\_) \_\_\_\_\_

If a physician did not refer you, who referred you to ENHMG Orthopaedic Surgery? \_\_\_\_\_

**When finished completing the questionnaire, please return to the front desk staff. Thank you.**