Orthopedic Surgery Medical History

Name		Occupation/Former Occupation			Today's Date	
Telephone #	Work #	Date of Birth	Age	Height	Weight	☐ Male ☐ Female

Medical History: *✓any illnesses or conditions you have had. If yes is checked, explain below:*

YES	NO		YES	NO		YES	NO	
☐	☐	Peripheral Vascular Disease	☐	☐	Neurologic	☐	☐	Bleeding Tendencies
☐	☐	History of Deep Venous Thrombosis	☐	☐	Heart Disease	☐	☐	Gastrointestinal Disease
☐	☐	Rheumatoid Arthritis	☐	☐	Liver Disease	☐	☐	Chronic Cough
☐	☐	Sciatica	☐	☐	Lung Disease	☐	☐	Dentures
☐	☐	TB	☐	☐	Kidney Disease	☐	☐	Contact Lenses
			☐	☐	Asthma	☐	☐	Hard of Hearing
			☐	☐	Diabetes	☐	☐	Cancer
						☐	☐	Other

If yes is checked on any questions – Explain: _____

Previous Operations (Dates & Name of Surgeon): _____

_____ _____

_____ _____

List other illnesses not requiring operation for which you were hospitalized: _____

_____ _____ _____

Have you had any serious injuries, broken bones, etc?

_____

List any allergies/sensitivities to any medications or other substances. List any SPECIFIC REACTIONS:

_____

_____

Current Medications & Dosages: _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Do you use tobacco now? ☐ YES ☐ NO	In the past? ☐ YES ☐ NO	Daily amount?	How long?	Do you use alcoholic beverages? ☐ YES ☐ NO	Weekly amount?

List your main orthopedic problems: _____

Date of onset of symptoms: _____

Previous treatment & dates: _____

Referring physician: _____

Primary Care Physician / Family or Medical Physician: _____