

REFERRED BY: \_\_\_\_\_

## MEDICAL HISTORY

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ DATE: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

Why are we seeing you today: **Right/Left** \_\_\_\_\_

\_\_\_\_\_

How long have you had this problem: \_\_\_\_\_

\_\_\_\_\_

Date of injury (if applicable) \_\_\_\_\_

Have you seen a doctor for this problem before?  Yes  No.

Please describe any treatment you received for this problem prior to your visit today \_\_\_\_\_

\_\_\_\_\_

Provider

Treatment given

Date/Location

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list any significant medical problems and/or history we should be aware of

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Medications:

Medication:

Dose:

Frequency:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

Are you allergic to any medications?  Yes  No.

Medicines you are allergic to:

What reaction did you have?

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Are you allergic to shell fish or iodine?  Yes  No.

Are you allergic to any type of metals?  Yes  No.

Are you allergic to latex?  Yes  No.

**Marital Status:**

Married: \_\_\_\_\_ Single: \_\_\_\_\_ Divorced: \_\_\_\_\_ Widowed: \_\_\_\_\_

How many children do you have? \_\_\_\_\_

How many siblings do you have? \_\_\_\_\_

Are there any issues regarding their health or development we should be aware of? \_\_\_\_\_

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**Social History:**

Do you use non-prescription or recreation drugs?  Yes  No

Do you currently smoke:  Yes  No

If no, have you smoked in the past?  Yes  No

Date you quit smoking \_\_\_\_\_

I drink alcohol (circle one): Not at all. Occasionally. Frequently.

**Surgical History:**

Have you ever had **ANY** type of surgery? (list orthopedic surgeries separately below)

Procedure

Surgeon

Date/Location

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Have you had **ANY ORTHOPEDIC** surgeries/procedures?

Procedure

Surgeon

Date/Location

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**Family History:**

Do members of your immediate family have a history of significant medical problems? (Circle all that apply):

Cancer.      Diabetes.      Heart Disease.      Problems with anesthesia.

Others \_\_\_\_\_

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Do you or ANYONE in your family have problems with anesthesia?  Yes  No  
If yes, please be specific \_\_\_\_\_

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Is there any additional information we should know? \_\_\_\_\_

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What questions would you specifically like answered today? \_\_\_\_\_

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What sports interest you? \_\_\_\_\_

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