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MEDICAL HISTORY

Name _____ Date _____

CHIEF COMPLAINT: (Please describe the recent events of your current orthopaedic problem. How long have you had problems? What makes it worse? What makes it less of a problem?)

ALLERGIES: (List and describe)

CURRENT MEDICATIONS: (Include dosage and frequency)

PREVIOUS SURGERIES: (List type of surgery and year)

FAMILY HISTORY: (List any medical illness affecting your immediate family; i.e. parents or siblings)

SOCIAL HISTORY:

A. Occupation _____

B. Do you smoke or use tobacco? Yes No

If yes, how much & how long _____

C. Do you use Alcohol? Never Occasionally Moderate Heavy

D. Living Arrangement Married Single Divorced Live Alone

GENERAL MEDICAL HISTORY:

Height _____ Weight _____

Are you affected by any of the following? If yes, please explain.

	NO	YES	EXPLAIN
Heart Disease (including hypertension, blood clots, mitral valve prolapse, pacemaker, etc.)			
Kidney Disease (dialysis, bladder, etc)			
Lung Disease (including asthma, tuberculosis, pleurisy, rheumatic fever, shortness of breath, etc.			
Gastrointestinal (including ulcer disease, hepatitis, jaundice, liver disease, etc.)			
Diabetes (if you take Blucophage or Metformin, please indicate)			
Neurologic (seizures, paralysis, numbness, weakness, etc.)			
Cancer			
Ear-Eye-Nose-Throat			
Genitourinary (urinary infections, incontinence, menopause, etc.)			
Musculoskeletal			