

PAST MEDICAL HISTORY

Patient Name: _____ Date: _____

FOR OFFICE USE ONLY

HEIGHT: _____ WEIGHT: _____ PULSE: _____ BLOOD PRESSURE: _____

WHAT PROBLEM BROUGHT YOU TO SEE AN ORTHOPAEDIST? HOW LONG HAVE YOU KNOWN ABOUT THIS PROBLEM? _____

DATE OF INJURY? _____ DESCRIBE ACCIDENT: _____

LIST ALL **SURGERIES** (except those listed under childhood surgeries): _____ NONE

LIST CHILDHOOD SURGERIES/HOSPITALIZATIONS: _____ NONE

LIST OTHER **HOSPITALIZATIONS** (for reasons other than surgery): _____ NONE

Reason: _____ Date: _____

Reason: _____ Date: _____

Reason: _____ Date: _____

Reason: _____ Date: _____

LIST MEDICAL **ILLNESSES** (and how long you have had them): _____ NONE

Illness: _____ How Long? _____

Illness: _____ How Long? _____

Illness: _____ How Long? _____

Illness: _____ How Long? _____

NAME OF FAMILY PHYSICIAN (PLUS PHONE NUMBER): _____

LIST ALL **MEDICINES** YOU ARE PRESENTLY TAKING (including dosage): _____

LIST ALL MEDICINE **ALLERGIES** OR DRUG ALLERGIES: _____

PHARMACY NAME: _____ PHONE: _____

HOW MUCH PER DAY DO YOU USE, IF ANY, OF THE FOLLOWING? Tobacco _____

Alcohol _____ Coffee/Tea _____ Special Diets? _____

HAVE ANY OF YOUR **BLOOD** RELATIVES HAD ANY OF THE FOLLOWING? Ulcers: _____

Stroke: _____ Gout: _____ Diabetes: _____ Bleeding Disorder: _____

High Blood Pressure: _____ Heart Attack/Disease: _____ Other: _____

Cancer (Describe): _____