Orthopedic Specialty
Medical History Documents

Date: _____

Patient Name: _____ DOB: _____

Past Medical History: (check all that apply)

- ☐ High Blood Pressure
- ☐ Hepatitis
- ☐ Osteoporosis
- ☐ Vascular Disease
- ☐ Glaucoma
- ☐ Thyroid Disease
- ☐ Gout
- ☐ Stomach or intestine disorder – such as gastrointestinal disorder, ulcers, or gallbladder diseases.
  If yes, please list: _____
- ☐ Neurological disorder – such as Parkinson's, multiple sclerosis or seizure disorder
  If yes, please list: _____
- ☐ Heart disease and/or conditions such as heart murmur, heart attack, heart failure, angina
  If yes, please list: _____
- ☐ Respiratory conditions such as asthma, bronchitis, pneumonia, COPD, or other
  If yes, please list: _____
- ☐ Blood / Bleeding disorder – such as ☐ anemia or ☐ hemophilia
- ☐ Diabetes – if yes, please specify type:
- ☐ Arthritis – if yes, please specify type if known:
- ☐ Cancer – if yes, please specify type:
- ☐ Other – Please provide any other medical history you would like to share: _____

_____

Patient Name: _____ DOB: _____

HAVE YOU HAD ANY PRIOR SURGERIES OR HOSPITALIZATIONS? ☐ YES ☐ NO

REASON:

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? ☐ YES ☐ NO

If YES – Please list below:

ARE YOU ALLERGIC TO ANY MEDICATIONS? ☐ YES ☐ NO

If YES – Please specify below and state the reaction:

Patient Name: _____ DOB: _____

FAMILY HISTORY:

Check all that apply	Father	Mother	Brother	Sister
Heart Disease	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐
Family History Unknown	☐	☐	☐	☐

SOCIAL HISTORY:

Do you currently smoke? ☐ Yes ☐ No

If Yes, how much per day? _____

Former Smoker ☐ Yes ☐ No

Did you have a drink containing alcohol in the past year? ☐ Yes ☐ No

If Yes, how many per day? _____

How many per week or month? _____

Exercise Routine: _____

WOMEN:

Are you pregnant? ☐ Yes ☐ No

Planning Pregnancy? ☐ Yes ☐ No

Patient Name: _____ DOB: _____

Do you presently have or have you recently had any of the following: ☐ Yes ☐ No
(If yes, check all that apply)

CONSTITUTIONAL
- ☐ Shaking, chills
- ☐ Night sweats
- ☐ Fatigue persistently or easily
- ☐ Fever
- ☐ Weight gain / Weight loss

MUSCULOSKELETAL
- ☐ Joint pain or swelling

NEUROLOGICAL
- ☐ Muscle weakness or paralysis
- ☐ Numbness in arms or legs
- ☐ Dizziness or headache

PSYCHIATRIC
- ☐ Depression
- ☐ Sleep disturbances / insomnia

CARDIOVASCULAR
- ☐ Chest pain
- ☐ Palpitations or irregular heart beat
- ☐ Varicose veins
- ☐ Swelling of feet or ankles

RESPIRATORY
- ☐ Chronic / recurrent cough
- ☐ Shortness of breath

GASTROINTESTINAL
- ☐ Abdominal pain
- ☐ Blood in stool / black stools
- ☐ Nausea or vomiting

HEMATOLOGIC
- ☐ Easy bruising
- ☐ Bleeding easily or hard to stop bleeding

IMMUNOLOGIC / ALLERGIC
- ☐ Severe food allergy
- ☐ Latex allergy
- ☐ Frequent infections

ANESTHESIA COMPLICATIONS
- ☐ Yes – Myself or family member
- ☐ No – No known anesthesia reactions

PATIENT SIGNATURE: _____ DATE: _____

Reviewed by: _____ Date: _____