MEDICAL HISTORY

Patient Name _____ **Date:**_____

Check all that apply to you.

- Alcohol Usage
- Allergies to anesthesia
- Allergies to drugs
- Allergies to metal
- Anemia
- Arthritis
- Asthma
- Blood clots
- Blood disorders
- Cancer
- Circulation problems
- Dexa scan screening
- Diabetes
- Drug Usage
- Gout
- Heart problems
- High blood pressure
- Infections
- Kidney problems
- Latex allergy
- Liver problems or hepatitis
- Lung problems
- Lyme disease
- Neurological problems
- Osteoporosis/Osteopenia
- Pregnancy, month_____
- Psychiatric disorders
- Pulmonary Embolism
- Radiation treatments
- Rheumatic fever
- Shortness of breath
- Stroke
- Thyroid
- Tick bite(s)
- Tobacco usage, ppd_____
- Tuberculosis
- Ulcer or colitis
- Venereal diseases
- Other_____

Referring Physician/Source:

_____

NAME *ADDRESS* *PHONE*

Family Physician's Name: _____ Date of last physical exam: _____

Patient Age: _____ Height: _____Weight: _____

Occupation: _____R. Handed: _____ L. Handed: _____

Date of accident or onset of complaint: _____Did this occur at work? _____

Why are you here today: _____

Smoking Status: _____ Current _____Former _____Never

Current Medical Problems: _____

Previous Surgeries:_____

Medications presently taking: _____

Allergies: _____

Previous bone or joint problems: _____

_____

Family medical history: _____

Statement of Corporation: The Corporation, Namely, Capital Region Orthopaedics will provide

Orthopaedic Treatment for _____ _____

(Name of patient) *(Signature of Patient or Guardian)*