

Physician: _____ Appointment Date: _____ Family Doctor: _____

MEDICAL HISTORY AND ORTHOPEDIC SCREEN

Patients Legal Name: _____ Birth Date: _____ Interpreter Needed - Language: _____

Referring Physician: _____

Preferred Pharmacy: (Name, Street, City, State) _____

• **MEDICATION HISTORY** Please list the names of All Medications (Include prescriptions, inhalers, topicals, vitamins, herbals, supplements, over-the-counter & birth control) which you are currently taking, **If you Have signed the Consent to obtain your Medication History from your Pharmacy** ~ only list vitamins, herbals, supplements & over-the-counter medications you are currently taking.

I am currently **NOT** taking any medication

Drug/Medicine	Amount/Dose	Frequency	Drug/Medicine	Amount/Dose	Frequency
(Example) Aspirin	81mg	1 tablet twice daily			

• **DRUG ALLERGIES** Please list All Drug and Anesthetic Allergies.

No Known Allergies

Drug/Other	Reaction	Drug/Other	Reaction

• **ORTHOPEDIC SURGERIES** Please include all (bone, joint, tendon, ligament, injury) surgeries you have ever had in your lifetime.

Date	Surgery / Procedure	Hospital / Physician

• **INTERVENTIONAL PAIN PROCEDURES** Please include any Epidurals for pain, Radiofrequency, Neuro Stimulators, Implantable Pain Pump, etc.

Date	Surgery / Procedure	Hospital / Physician

• **OTHER HOSPITAL ADMISSIONS/PROCEDURES** Please include any other Surgeries or Hospitalizations you have ever had in your lifetime.

Date	Surgery / Procedure / Hospitalization

• **ANESTHESIA** Please check any of the following Anesthesia conditions you have had or now have:

- Previous Anesthesia Reaction. Please indicate the type of reaction you had: _____
- A Family Member has had an Anesthesia reaction. (Mom, Dad, Siblings): _____
- I wear Dentures. (Partial or Full)

• **ALLERGIES/SENSITIVITIES**

Latex Allergy/Sensitivity – I have had or now have repeated reactions to Latex? No Yes

➢ What caused your reaction? _____ What was your reaction? _____

➢ Do you handle other Latex or Rubber items Without a reaction? No Yes

➢ Have you ever had a blood test for Latex Allergy? No Yes Date: _____ Results: Negative Positive (Have Allergy)

Metal Sensitivity

➢ I have had or now have repeated reactions to metal. No Yes

➢ What caused your reaction? _____ What was your reaction? _____

• **FRACTURES/DISLOCATIONS** Please list any non-surgical fractures or dislocations with approximate date or age they occurred.

Fracture/Dislocation	Approximate Date or Age

• **IMPLANTS**

Please list any Implants you currently have (Pacemaker, AICD (Automatic Internal Cardiac Defib), Pain Pump, Neurostimulator, Eye, Ear, Spine etc.)

Type of Implant	Manufacturer	Model	Serial/Model#	Date Implanted

****COMPLETE BOTH SIDES****

• MUSCULOSKELETAL HISTORY

Please list any Musculoskeletal condition you have had or now had (Arthritis, Joint Problems, Joint Infections, Spine Problems, Fibromyalgia, etc.)

• GENERAL HEALTH HISTORY Please check any of the following conditions you have had or now have:

<input type="checkbox"/> Thyroid Disease Type: _____	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Cancer Type: _____
<input type="checkbox"/> Asthma	<input type="checkbox"/> MI/Heart Attack Date: _____	<input type="checkbox"/> G.I. Bleeding
<input type="checkbox"/> Diabetes <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2	<input type="checkbox"/> Atrial-Fibrillation	<input type="checkbox"/> Sleep Apnea
Controlled By: _____	<input type="checkbox"/> Coronary Artery Disease (CAD)	<input type="checkbox"/> Uses C-PAP Machine
Last A1C _____ Date: _____	<input type="checkbox"/> Peripheral Vascular Disease (PVD)	<input type="checkbox"/> Arrhythmia
Physician Managing your Diabetes _____	<input type="checkbox"/> Hypertension & currently taking medication	<input type="checkbox"/> DVT (Deep Vein Thrombosis)
Last Visit Date: _____	<input type="checkbox"/> Stroke – on Blood Thinner <input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> PE (Pulmonary Embolus)
Last Routine Foot Care Date: _____	~ on Blood Thinner <input type="checkbox"/> No <input type="checkbox"/> Yes Name: _____	Cardiologist: _____

Please list any OTHER General Health History you did not indicate above (Anemia, Multiple Sclerosis, Peptic Ulcer, Colitis, Kidney Disease, Hepatitis – A,B,C, Liver Disease, Peripheral Neuropathy, Depression, Anxiety, Congestive Heart Failure, Pulmonary Disease, Bleeding Disorder, etc.)

• DRUG RESISTANT INFECTIONS

MRSA Date: _____ Details: _____

VRE Date: _____ Details: _____

TB Date: _____ Details: _____

• IMMUNIZATIONS

Tetanus No Yes Date: _____

Pneumonia No Yes Date: _____

Flu No Yes Date: _____

• FOR WOMEN

Age at onset of menstruation: _____ Age at onset of menopause: _____

If you are Age 65-85 ~ Have you ever had a Bone Density Test (DXA Scan)? No Yes Test Date: _____

If you are Age 40-69 ~ Have you ever had a Mammogram? No Yes Mammogram Date: _____

If you have had a Mastectomy, please indicate - Date: _____ Type/Side: _____

• CANCER SCREENING

If you are Age 50-75 ~ Have you ever had a Colorectal Cancer Screening? No Yes

Colonoscopy No Yes Date: _____ Sigmoidoscopy No Yes Date: _____

• TOBACCO USE Have you **Ever** used Tobacco? No/NEVER Yes

Smoking Tobacco Use					Non-Smoking Tobacco Use				
Tobacco Type	Use Daily	Usage per Day	Age 1 st Started	Age Stopped	Tobacco Type	Use Daily	Usage per Day	Age 1 st Started	Age Stopped
<input type="checkbox"/> Cigarette	<input type="checkbox"/> Yes	# _____ <input type="checkbox"/> Packs or <input type="checkbox"/> Cigarettes			<input type="checkbox"/> Chewing	<input type="checkbox"/> Yes	# _____ Units		
<input type="checkbox"/> Cigarillo	<input type="checkbox"/> Yes	# _____ Cigarillos			<input type="checkbox"/> Smokeless	<input type="checkbox"/> Yes	# _____ Units		
<input type="checkbox"/> Cigar	<input type="checkbox"/> Yes	# _____ Cigars			<input type="checkbox"/> Snuff	<input type="checkbox"/> Yes	# _____ Units		
<input type="checkbox"/> Pipe	<input type="checkbox"/> Yes	# _____ Pipes			<input type="checkbox"/> _____	<input type="checkbox"/> Yes	# _____ Units		

• ALCOHOL USE No Yes Number of drinks _____ per Day Week Month ~ Date Quit: _____

• RECREATIONAL SUBSTANCE/DRUG USE No Yes Type: _____ Frequency: _____ ~ Date Quit: _____

• CAFFEINE USE No Yes Number of drinks _____ per Day Week Month

• STUDENTS School: _____ Sports: _____ Fitness Activities: _____

• HOME ENVIRONMENT Does your Home have a full flight of stairs? No Yes

Lives Alone Lives with spouse/other relatives Assisted Living Nursing Home Retirement Home

Lives with other adult(s) able to provide care Caregiver for person living in my home

• WORK ENVIRONMENT Have you served in the Military? No Yes

Part Time Full Time Self Employed Unemployed Retired Occupation: _____

• FAMILY HISTORY Please list any Medical Conditions of you Mother, Father & Siblings Family History Unknown

Family Member	List any Health Condition(s) your Family Member has had (other than cause of Death if Deceased)	If Deceased
Mother		Age: Cause:
Father		Age: Cause:
Sibling		Age: Cause:
Sibling		Age: Cause:
Sibling		Age: Cause:

****COMPLETE BOTH SIDES****