

PAST MEDICAL HISTORY

INSTRUCTIONS:

Please review the instructions as listed on the enclosed page. The questions to follow will refer to your overall health. **PLEASE PRINT CLEARLY.**

Please use a separate sheet of paper if needed to record additional information or details on your medical history.

LIST YOUR MEDICAL PROBLEMS:

ث None

1. _____
Currently being treated: ث Yes ث No

2. _____
Currently being treated: ث Yes ث No

3. _____
Currently being treated: ث Yes ث No

4. _____
Currently being treated: ث Yes ث No

5. _____
Currently being treated: ث Yes ث No

6. _____
Currently being treated: ث Yes ث No

7. _____
Currently being treated: ث Yes ث No

CURRENT MEDICATIONS:

<u>Medication</u> _____	<u>Medication</u> _____
<u>Dose/Frequency</u> _____	<u>Dose/Frequency</u> _____

1. _____

6. _____

2. _____

7. _____

3. _____

8. _____

4. _____

9. _____

5. _____

10. _____

PAST MEDICAL HISTORY

(Continued)

Are you experiencing any problems with the following:

(Please check off yes or no and circle all that apply)

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
General Health (weight loss, sweats, fevers)	ف	ف	Circulation	ف	ف
Eyes	ف	ف	Gout	ف	ف
Ears, Nose Throat	ف	ف	Stroke/Seizures	ف	ف
Heart/Hypertension	ف	ف	Diabetes/Thyroid	ف	ف
Lungs	ف	ف	(Recent/ongoing)		
Ulcer/Bowels/Liver	ف	ف	Infection	ف	ف
Acid Reflux	ف	ف	Cancer	ف	ف
Kidney/Urinary Tract	ف	ف	Skin	ف	ف
Prostate	ف	ف	Emotional/Psychiatric		
Rheumatoid arthritis	ف	ف	Disorders	ف	ف
			Gynecologic	ف	ف

If **YES**, explain: _____

ORTHOPEDIC PROBLEMS: (Check all areas with which you have had problems)

- Back
 Neck
 Shoulder
 Arm
 Hand
 Elbow
 Wrist
 Hip
 Knee
 Leg
 Ankle
 Foot

ALLERGIES/ADVERSE DRUG REACTIONS:

List your past allergies:

Environmental

<u>Drug</u>	<u>Reaction</u>
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

PAST MEDICAL HISTORY

(Continued)

WOMEN ONLY:

Are you pregnant? ڤ Yes ڤ No ڤ Maybe
 Have you reached menopause? ڤ Yes ڤ No ڤ Maybe

SOCIAL HISTORY:

Marital Status: ڤ Single ڤ Married ڤ Divorced ڤ Other

Occupation: _____

Do you **Smoke**? ڤ Yes ڤ No
 If Yes, ڤ Cigarettes, _____ packs per day for _____ years.
 ڤ Cigars ڤ Chewing tobacco
 ڤ Other: _____

Quit: ڤ When: _____

Do you drink **Alcoholic** beverages? ڤ Yes ڤ No
 Type: _____ Amount/Frequency: _____

Are you at risk for **HIV** (Aids) ? ڤ Yes ڤ No
 For example – blood transfusion(s), intravenous drug use, unprotected sexual contact.

Details: _____

FAMILY HISTORY:

List serious medical problems that your blood relatives (father, mother, sisters, brothers, etc.) have experienced:

1. Relative _____ ڤ Living ڤ Deceased

Problem _____

2. Relative _____ ڤ Living ڤ Deceased

Problem _____

3. Relative _____ ڤ Living ڤ Deceased

Problem _____

(Forms/PMH-sheet pg4)

PAST MEDICAL HISTORY

(Continued)

FAMILY HISTORY: (Continued)

4. Relative _____ ف Living ف Deceased

Problem _____

5. Relative _____ ف Living ف Deceased

Problem _____

SURGICAL RISK FACTORS:

Have you ever been treated for a blood clot....

.....in your leg(s)? ف Yes ف No

.....in your lung(s)? ف Yes ف No

Have you or any relatives had a problem with....

.....Bleeding ف Yes (self) ف No ف Yes (Relative)

.....Anesthesia ف Yes (self) ف No ف Yes (Relative)

Have any of your relatives died during or soon after surgery? ف Yes ف No

Details to "yes" responses: _____

PEDIATRIC PATIENTS:

ف Not/Applicable

Birth History:

ف Normal Full Term

ف Breech

ف Premature

ف First Born

(Forms/PMH-sheet pg5)