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:

☐ Thyroid Disease Type: _____
☐ Asthma
☐ Diabetes ☐ Type 1 ☐ Type 2
Controlled By: _____
Last A1C _____ Date: _____
Physician Managing your Diabetes _____
Last Visit Date: _____
Last Routine Foot Care Date: _____

☐ High Cholesterol
☐ MI/Heart Attack Date: _____
☐ Atrial-Fibrillation
☐ Coronary Artery Disease (CAD)
☐ Peripheral Vascular Disease (PVD)
☐ Hypertension & currently taking medication
☐ Stroke – on Blood Thinner ☐ No ☐ Yes

☐ Cancer Type: _____
☐ G.I. Bleeding
☐ Sleep Apnea
☐ Uses C-PAP Machine
☐ Arrhythmia
☐ DVT (Deep Vein Thrombosis)
☐ PE (Pulmonary Embolus)

~ on Blood Thinner ☐ No ☐ 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 1st Started	Age Stopped	Tobacco Type	Use Daily	Usage per Day	Age 1st Started	Age Stopped
☐ Cigarette	☐ Yes	# ___ ☐ Packs or ☐ Cigarettes			☐ Chewing	☐ Yes	# ___ Units		
☐ Cigarillo	☐ Yes	# ___ Cigarillos			☐ Smokeless	☐ Yes	# ___ Units		
☐ Cigar	☐ Yes	# ___ Cigars			☐ Snuff	☐ Yes	# ___ Units		
☐ Pipe	☐ Yes	# ___ Pipes			☐ _____	☐ 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

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• **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****