

Medical History

Date: _____

Name: _____ Male Female Date of Birth: ___ / ___ / ___

Reason for appointment: Right Left Body Part: _____

Current Height: _____ Current Weight: _____ Are you: Left handed Right handed

Pharmacy: Please provide us with the name and location of your pharmacy.

Pharmacy Name: _____ Location: _____

Allergies: None known or Do you have reactions to any of the following? Describe.

Penicillin: _____ Codeine: _____ Latex: _____

Sulfa: _____ Oxycodone: _____ Tapes: _____

Iodine Contrast: _____ Hydrocodone: _____ Other: _____

Current Medications: Include the dose and how often the medication is taken (Include Over the Counter Products and Supplements)

If insufficient space, please use back side of page.

LIST ALL BELOW See Attached/Scanned List or Not Taking Any Medications

Vaccines: Influenza (flu) immunization: No Yes, date _____ Pneumococcal (pneumonia) vaccine: No Yes, date _____

Family History: None

Bleeding problems Blood clotting disorder Complications of anesthesia, describe _____

Diabetes Heart disease Malignant hyperthermia Osteoporosis Pulmonary embolism

Other (specify): _____

Personal/Social History:

Relationship Status: Single Married Divorced Separated Widowed

Residence: Alone With Others Nursing Home Retirement Home Other: _____

Employed: No Yes Occupation: _____

Children: No Yes How many?: _____ If female, pregnant? No Yes

Do you have an Advanced Directive: No Yes

Smoking / Tobacco History: No history of tobacco use Quit smoking/tobacco. How long ago did you quit? _____

Current tobacco use Cigarettes _____ packs a day for _____ years Cigars _____ years

Smokeless Tobacco: Patches _____ years Chewing tobacco _____ years E-cigarettes _____ years

Marijuana use

Alcohol Consumption: None Occasional Moderate Heavy

History of Substance Abuse: No Yes If yes, please describe: _____

Exercise level: None Occasional Moderate Heavy

Surgical History

Please describe below any orthopaedic surgeries. Include the procedure, side (left or right), and the year.

Hip: _____

Knee: _____

Shoulder: _____

Other Orthopaedic Surgeries: _____

Spine Surgery: Type & year: _____

