

Orthopedics & Sports Medicine

Patient Name _____ Date of Birth _____ Date _____

Past Patient Medical History

Measles <input type="checkbox"/> No <input type="checkbox"/> Yes	Anemia <input type="checkbox"/> No <input type="checkbox"/> Yes	Bladder Infections <input type="checkbox"/> No <input type="checkbox"/> Yes
Mumps <input type="checkbox"/> No <input type="checkbox"/> Yes	Blood Transfusions <input type="checkbox"/> No <input type="checkbox"/> Yes	Kidney Disease <input type="checkbox"/> No <input type="checkbox"/> Yes
Chickenpox <input type="checkbox"/> No <input type="checkbox"/> Yes	Hepatitis <input type="checkbox"/> No <input type="checkbox"/> Yes	Heart Disease <input type="checkbox"/> No <input type="checkbox"/> Yes
Rheumatic Fever <input type="checkbox"/> No <input type="checkbox"/> Yes	Ulcer <input type="checkbox"/> No <input type="checkbox"/> Yes	Mitral Valve Prolapse <input type="checkbox"/> No <input type="checkbox"/> Yes
Polio <input type="checkbox"/> No <input type="checkbox"/> Yes	Bleeding Tendency <input type="checkbox"/> No <input type="checkbox"/> Yes	Stroke <input type="checkbox"/> No <input type="checkbox"/> Yes
Tuberculosis <input type="checkbox"/> No <input type="checkbox"/> Yes	Asthma <input type="checkbox"/> No <input type="checkbox"/> Yes	Seizures <input type="checkbox"/> No <input type="checkbox"/> Yes
Hives or Eczema <input type="checkbox"/> No <input type="checkbox"/> Yes	Pneumonia <input type="checkbox"/> No <input type="checkbox"/> Yes	Blood Pressure <input type="checkbox"/> No <input type="checkbox"/> Yes
Bronchitis <input type="checkbox"/> No <input type="checkbox"/> Yes	Thyroid Disease <input type="checkbox"/> No <input type="checkbox"/> Yes	Rheumatoid Arthritis <input type="checkbox"/> No <input type="checkbox"/> Yes
Diabetes <input type="checkbox"/> No <input type="checkbox"/> Yes	Depression <input type="checkbox"/> No <input type="checkbox"/> Yes	Cancer <input type="checkbox"/> No <input type="checkbox"/> Yes
Glaucoma <input type="checkbox"/> No <input type="checkbox"/> Yes	Back Trouble <input type="checkbox"/> No <input type="checkbox"/> Yes	Type _____
Osteo Arthritis <input type="checkbox"/> No <input type="checkbox"/> Yes		

If yes, please explain _____

Allergies/Reaction if known None _____

Medications

Surgeries

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient Social History

Marital Status: Single Married Separated Divorced Widowed Other
 Use of alcohol: Never Rarely Moderate Daily
 Use of tobacco: Never Previously, but quit: _____ Current packs/day _____
 Use of drugs: Never Type/frequency: _____
 Excessive exposure
 At home or work to: Fumes Dust Solvents Airborne Particles Noise

Family Medical History

	Age	Diseases	If deceased, cause of death
Father _____	_____	_____	_____
Mother _____	_____	_____	_____
Siblings _____	_____	_____	_____

Do you have problems with any of the following that might effect your care or understanding of your medical condition or treatment?

Physical <input type="checkbox"/> Yes <input type="checkbox"/> No	Emotional <input type="checkbox"/> Yes <input type="checkbox"/> No	Reading <input type="checkbox"/> Yes <input type="checkbox"/> No
Cognitive <input type="checkbox"/> Yes <input type="checkbox"/> No	Spiritual <input type="checkbox"/> Yes <input type="checkbox"/> No	Writing <input type="checkbox"/> Yes <input type="checkbox"/> No
Cultural <input type="checkbox"/> Yes <input type="checkbox"/> No	Visual <input type="checkbox"/> Yes <input type="checkbox"/> No	Speech <input type="checkbox"/> Yes <input type="checkbox"/> No
Language <input type="checkbox"/> Yes <input type="checkbox"/> No	Hearing <input type="checkbox"/> Yes <input type="checkbox"/> No	Religion _____

Advanced Directive

Do you have an advanced directive? ___ Yes ___ No If yes, do we have a copy of your advanced directive on file? ___ Yes ___ No
 If no, we need a copy of your advanced directive for your medical record. If you do not an advanced directive and would like more information on this subject, there is a handout available.

Signed _____ Date _____

Relationship, if other than the Patient _____

Witness _____ Date _____