

Medical History

Name _____ Date of Birth _____ Date _____

Medical Doctor: Name _____

Address _____ Telephone _____

Describe any medical problems for which you are currently being treated _____

During the past year, have you been admitted to the hospital for any medical problems? If so, please explain.

Please list any operations and approximate dates: _____

Are you allergic to any medications? No Yes If yes, please list _____

List name, dose, and frequency of all medications currently being taken: _____

Do you have or have you ever had any of the following? Check yes or no:

	Yes	No		Yes	No		Yes	No
Seizure	<input type="checkbox"/>	<input type="checkbox"/>	Weight gain or loss	<input type="checkbox"/>	<input type="checkbox"/>	Skin Rashes	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer/Reflux Problems	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts/Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>
Other eye problems	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Infection/Stones	<input type="checkbox"/>	<input type="checkbox"/>	HIV Infection/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Bladder problems	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Lung Problems	<input type="checkbox"/>	<input type="checkbox"/>	Prostate problems	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety/Depression	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Ovary/Uterus Problems	<input type="checkbox"/>	<input type="checkbox"/>	Other		
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Circulation Problems	<input type="checkbox"/>	<input type="checkbox"/>			
Angina	<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis/Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>			
Heart Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>			

Briefly explain if you checked yes _____

Have any family members had orthopaedic problems? No Yes If yes, who and explain problem _____

Single Married Widowed Divorced With whom do you live? _____ House Apartment

Do you smoke? No Yes If yes, how much? _____ pack(s)/day

What do you do for recreation/hobbies? _____

Do you exercise? No Yes If yes, describe _____ Frequency _____

If employed, by whom _____ Job description _____

Patient Signature

Date

Physician Signature

Date