



## MEDICAL HISTORY

M F

Name \_\_\_\_\_ Age \_\_\_\_\_ Family Doctor \_\_\_\_\_

*Please check ALL boxes below indicating your current conditions*

MEDICAL PROBLEMS	YES	NO
Arthritis		
Fibromyalgia		
Gout		
High blood pressure		
Coronary artery disease		
Heart attack		
Congestive heart failure		
History of phlebitis/Blood clot		
Stroke		
Pacemaker		
Asthma		
Emphysema		
Pulmonary embolism		
Ulcers		
Hepatitis		
Kidney disease/Renal failure		
Kidney stones		
Diabetes		
Thyroid disease		
Psoriasis		
Seizure disorder		
Cancer		
Other:		

ORTHO HISTORY	Year	Hospital	Doctor
Arthroscopy			
Bunion			
Carpal tunnel			
Cervical fusion			
Hip replacement			
Knee replacement			
Laminectomy			
Other:			

### ASSISTIVE AIDS

Circle Answer

Glasses	Dentures	Hearing Aid	Cane	Walker	Brace
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### FAMILY HISTORY

Number of children					
Circle Answer that applies to each:	F - Father, M - Mother, G - Grandparent, B - Brother, S - Sister				
Anemia	F	M	G	B	S
Arthritis	F	M	G	B	S
Bleeding disorder	F	M	G	B	S
Cancer	F	M	G	B	S
Diabetes	F	M	G	B	S
Heart disease	F	M	G	B	S
High blood pressure	F	M	G	B	S
Stroke	F	M	G	B	S
Anesthesia Complications	F	M	G	B	S

SURGICAL HISTORY	Year	Hospital
Anesthesia complications		
Appendectomy		
Colon resection		
Gallbladder		
Heart bypass (CABG)		
Heart valve replacement		
Hernia repair		
Hysterectomy		
Kidney stones		
Mastectomy		
Tonsillectomy		
Tubal ligation		
Other:		

### SOCIAL HISTORY

Circle Answer

Marital Status:	S	M	D	W
Hand Dominance:	R	L	Both	
Work Status:	Student	Housewife	Not Working	Working
	Retired	Disabled	Injured	
	Off work since:	Disabled since:		
Occupation:				
Employer:				
Tobacco use:	Never	Former	Current	_____ packs/day_____ yrs.
Alcohol use:	Never	Former	Current	Daily Weekly Occasional
Drug abuse:	Never	Former	Current	
	Heroin	Cocaine	Marijuana	Other_____
Exercise:	Never	1-3x/month	1-3x/week	Daily