PATIENT MEDICAL HISTORY

Patient Name _____
Social Security Number _____
Date _____ Ht _____ Wt _____

Past Medical History
Have you had any medical problems?

High Blood Pressure	Yes	No
Heart Disease	Yes	No
Stroke	Yes	No
Obstructive Pulmonary Disease	Yes	No
Kidney Disease	Yes	No
AIDS/ HIV	Yes	No
Rheumatoid Arthritis	Yes	No
Diabetes	Yes	No

Please list all medications you are currently taking, including dietary suppliments

*** Circle One of the following ***

1) None 2) See Attached List

Past Surgical History
Please list any operations you have had
None Yes No

_____
_____
_____

Allergies, List all drugs to which you are allergic

_____
_____
_____

Review of systems
Do you have any of theses symptons?

Constitutional

Fever	Yes	No
Weight loss/gain	Yes	No

Heart

Chest pain	Yes	No
Irregular heart beat	Yes	No
Poor circulation	Yes	No

Genitournary

Bloody urine	Yes	No
Pain on urinating	Yes	No
Unable to urinate	Yes	No

Neurological

Paralysis	Yes	No
Frequent headaches	Yes	No

Blood

Bleeding problems	Yes	No
Previous transfusion	Yes	No

Please circle either Yes or No for each condition

Eyes

Decreased vision	Yes	No
Cataracts	Yes	No

Lungs

Shortness of breath	Yes	No
Wheezing	Yes	No
Persistent cough	Yes	No

Musculoskeletal

Joint swelling	Yes	No
Muscle aches	Yes	No
Joint pain	Yes	No

Psychiatric

Depression	Yes	No
Bipolar disease	Yes	No

Allergic

Allergies to food	Yes	No
Medicines	Yes	No

Ear, Nose, & Throat

Loss of Hearing	Yes	No
Sinus problems	Yes	No

Gastrointestinal

Stomach pains	Yes	No
Diarrhea	Yes	No
Persistent vomiting	Yes	No

Skin

Rash	Yes	No
Dryness of skin	Yes	No

Endocrine

Thyroid problems	Yes	No
Diabetes	Yes	No

Others

_____
_____

Social History
Do you use?

Tobacco	Yes	No
Alcohol	Yes	No

Do you have or had a problem with chemical dependency?
Yes No

Are you pregnant? Yes No

Family History
Has anybody in your family had any of these conditions?

Heart Disease	Yes	No
Stroke	Yes	No
Cancer	Yes	No
Bleeding disorder	Yes	No

TRI-COUNTY ORTHOPAEDICS, P.A.
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