Patient Medical History

Today's Date: _____ Patient Name: _____ Date of Birth: _____

Current/Past Medical History	Yes	No
Aids		
Alzheimer's/Dementia		
Anxiety/Depression		
Arthritis		
Asthma		
Bi-Polar		
Bladder Problems		
Bleeding Problems		
Cancer		
If yes, list type: _____		
COPD		
Diabetes		
If yes, check type 1 ☐ Type 2 ☐		
Epilepsy		
Heart Attack		
Heart Problems		
If yes, what kind: _____		
Hepatitis		
High Blood Pressure		
Shortness of breath		
Metal Implants		
Osteoporosis		
Pacemaker/Defibrillator		
Polio		
Stroke		
Thyroid Problems		
Tuberculosis (TB)		

Additional Diagnosis not Listed Above:

_____

_____

_____

_____

DEXA Scan - Bone Density Study
(Female age 65 & older only)
☐ Yes, Estimated date: _____
☐ No

Currently Pregnant
☐ Yes ☐ No

Smoking Status:
☐ Never Smoker
☐ Current Smoker Start Date: _____
☐ Former Smoker Quite Date: _____
- ☐ 1-5 years ago
- ☐ 5+ years ago
- ☐ 10+ years ago

Recreational Drug Use:
Do you use recreational drugs?
☐ Yes ☐ NO ☐ Past history of Use
If yes, what type?
☐ Marijuana ☐ Cocaine ☐ "Crystal Meth" ☐ Heroin

Caffeine:
Do you consume caffeine?
☐ Yes ☐ No
If Yes, how often?
☐ Daily ☐ Rarely ☐ Occasionally

History of Falls (Age 65 & older only)
☐ Yes ☐ No
In the past year, have you fallen 2 or more times?
☐ Yes ☐ No
Was there an injury due to the fall(s)?
☐ Yes ☐ No
Were you referred to a doctor for balance issues?
☐ Yes ☐ No

Exercise:
Do you currently exercise: ☐ Yes ☐ No ☐ Unable
If yes, how often?
☐ Daily ☐ Regularly ☐ Rarely

ORTHOPEDIC ASSOCIATES

Patient Medical History

Patient Name: _____ Date of Birth: _____

Current Medications:

You may provide a medicaion list to the front desk to scan i if you have a list.

Did you bring a medication list? ☐ Yes ☐ No

Medication Name	Dosage	Frequency	Route

Do you have an allergy to metal? ☐ Yes ☐ No

List Allergies

Medication Allergy	Reaction

List Past Surgeries

Year of Surgery	Surgery & Surgery Location

Hospitalizations

Year	Reason