SOUTHWEST MICHIGAN CENTER FOR ORTHOPAEDICS & SPORTS MEDICINE

Medical History Form

Today's Date:_____

Patient Name:_____ **Date of Birth:**_____

Age:_____ Do prefer to be called by a different name?_____

Present Orthopaedic Problem:_____

Please Circle one: RIGHT LEFT

Date of Injury / onset:_____ Did this occur at work?_____

Have you ever had problems like this before:_____ When:_____

Please Describe how the injury happened:_____

_____

Have you seen any other physicians for this problem:_____ Who:_____

Were any tests or treatments done:_____

Were any x rays or other images taken:_____Where:_____When:_____

Who referred you to our office:_____

Who is your family physician:_____

Do you see a Cardiologist (heart doctor):_____

Please list all current medications you are now taking, including over the counter medications

Medication	Dosage	Frequency

Do you have a Latex Allergy?_____

Do you have an allergy to any medications? _____

If so which Medications, and their reactions:_____

_____

Do you have Obstructive Sleep Apnea?_____

Surgical History:

Have you had any of the following surgeries? If so when?

Angioplasty / Angiogram	Y	N_____	Bone / Joint	Y	N_____
Open Heart Surgery	Y	N_____	Prostate	Y	N_____
Carotid Surgery	Y	N_____	Hysterectomy	Y	N_____
Gall Bladder	Y	N_____	Thyroid	Y	N_____
Breast Surgery	Y	N_____	Hernia	Y	N_____
Vascular Surgery	Y	N_____	Back	Y	N_____
Appendectomy	Y	N_____	Nasal	Y	N_____
Tonsillectomy	Y	N_____	Vasectomy	Y	N_____
Neuro Surgery	Y	N_____	Tubal Ligation	Y	N_____

Please list any and all other surgeries you have had:_____

_____

Medical History:

Are you currently having, or have you ever had any of the following problems? Please give approx date if **YES**.

Heart:

Palpitations Y N_____
Heart Attack Y N_____
C H F Y N_____
(congestive heart failure)
Hypertension Y N_____
(high blood pressure)

Lungs:

Asthma Y N_____
Emphysema Y N_____
C O P D Y N_____
(chronic obstructive pulmonary disease)
Chronic Cough Y N_____

Gastrointestinal:

Hiatal Hernia Y N_____
Digestion Y N_____
Ulcers Y N_____
Blood in Stool Y N_____
IBS Y N_____
(irritable bowel syndrome)
Tuberculosis Y N_____

Skin:

Eczema Y N_____
Psoriasis Y N_____
Skin Cancer Y N_____

Vascular:

Vericose Veins Y N_____
C A B G Y N_____
(coronary artery bypass graft)
Stents Y N_____

Neurological:

Seizures Y N_____
Epilepsy Y N_____
Depression Y N_____
Anxiety Y N_____
Blackout/fainting Y N_____
Headaches Y N_____
Stroke Y N_____
Balance Problems Y N_____
Numbness/tingling Y N_____

Endocrine:

Thyroid Disease Y N_____
Diabetes Y N_____
Kidney Problems Y N_____
Difficult/ painful urination Y N_____

General:

Cancer Y N_____
(what kind)_____
Bleeding Problems Y N_____
High Cholesterol Y N_____
Eye Problems Y N_____
Ears, Nose, Throat Y N_____
Polio Y N_____
Fractures/ Broken Bones Y N_____
(which one)_____
Any bone or joint surgery? please explain

_____

_____

Have you ever had a problem with an anesthetic during surgery?_____
If YES please explain._____

_____

Social History:

Do you smoke? _____ How many packs per day?_____

How long have you smoked?_____

Do you drink alcoholic beverages?_____ How often?_____How many per week?_____

Do you use recreational drugs?_____What kind?_____
How often?_____

Marital Status:

Please circle one: Married Single Divorced Widowed Separated

Work Status:

Please circle one: Working Retired Disabled Homemaker

If working Occupation:_____

Employer:_____

Family History:

Have any direct relatives (mother, father, sister, brother) had any of the following disorders?

Diabetes_____ if so, who?_____

High Blood Pressure_____if so, who?_____

Heart disease_____ if so who?_____

Rheumatoid Arthritis_____ if so who?_____

Patients printed name_____

Name of person completing this form if not the patient:_____

Relationship to the patient_____

Signature:_____ Date:_____

Form reviewed by:_____ Date:_____