NORTHWEST ORTHOPAEDIC SPECIALISTS

NWOrthopaedicSpecialists.com

Medical History

Date: _____

Name: _____ ☐ Male ☐ Female Date of Birth: ____ / ____ / ____

Reason for appointment: ☐ Right ☐ Left Body Part: _____

Current Height: _____ Current Weight: _____ Are you: ☐ Left handed ☐ Right handed

Pharmacy: *Please provide us with the name and location of your pharmacy.*

Pharmacy Name: _____ Location: _____

Allergies: ☐ None known *or Do you have reactions to any of the following? Describe.*

☐ Penicillin: _____ ☐ Codeine: _____ ☐ Latex: _____

☐ Sulfa: _____ ☐ Oxycodone: _____ ☐ Tapes: _____

☐ Iodine Contrast: _____ ☐ Hydrocodone: _____ ☐ Other: _____

Current Medications: *Include the dose and how often the medication is taken (Include Over the Counter Products and Supplements) If insufficient space, please use back side of page.*

LIST ALL BELOW ☐ See Attached/Scanned List *or* ☐ Not Taking Any Medications

Vaccines: Influenza (flu) immunization: ☐ No ☐ Yes, date _____ Pneumococcal (pneumonia) vaccine: ☐ No ☐ Yes, date _____

Family History: ☐ None

☐ Bleeding problems ☐ Blood clotting disorder ☐ Complications of anesthesia, describe _____

☐ Diabetes ☐ Heart disease ☐ Malignant hyperthermia ☐ Osteoporosis ☐ Pulmonary embolism

☐ Other (specify): _____

Personal/Social History:

Relationship Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Residence: ☐ Alone ☐ With Others ☐ Nursing Home ☐ Retirement Home ☐ Other: _____

Employed: ☐ No ☐ Yes Occupation: _____

Children: ☐ No ☐ Yes How many?: _____ If female, pregnant? ☐ No ☐ Yes

Do you have an Advanced Directive: ☐ No ☐ Yes

Smoking / Tobacco History: ☐ No history of tobacco use ☐ Quit smoking/tobacco. How long ago did you quit? _____

☐ Current tobacco use ☐ Cigarettes _____ packs a day for _____ years ☐ Cigars _____ years

Smokeless Tobacco: ☐ Patches ____ years ☐ Chewing tobacco ____ years ☐ E-cigarettes ____ years

☐ Marijuana use

Alcohol Consumption: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

History of Substance Abuse: ☐ No ☐ Yes If yes, please describe: _____

Exercise level: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Surgical History

Please describe below any orthopaedic surgeries. Include the procedure, side (left or right), and the year.

Hip: _____

Knee: _____

Shoulder: _____

Other Orthopaedic Surgeries: _____

Spine Surgery: Type & year: _____

Please mark or list any other surgeries you have had in the past:

- ☐ Appendectomy
- ☐ Hysterectomy
- ☐ Hernia
- ☐ Tonsillectomy
- ☐ Oophorectomy
- ☐ Mastectomy
- ☐ Gallbladder
- ☐ C-section
- ☐ Varicose Veins
- ☐ Bypass/Heart surgery, when? _____
- ☐ Angioplasty/Stent, when? _____

Other surgeries not listed above: _____

_____

Past Medical History ☐ No Illnesses *(Please check all that apply)*

- ☐ AIDS/HIV
- ☐ Anxiety
- ☐ Asthma
- ☐ Bladder/Kidney infection
- ☐ Bleeding disorders
- ☐ Bronchitis
- ☐ Cancer
- ☐ C-Diff
  - ☐ Active infection
  - ☐ Successfully treated
- ☐ Dentures/Partials
- ☐ Depression
- ☐ Diabetes
- ☐ DVT (blood clots)
- ☐ Emphysema
- ☐ Fractures – List types:___ _____
- ☐ Heart attack
- ☐ Heart disease
- ☐ Heart murmur/irregular rhythm
- ☐ Hepatitis ☐ A ☐ B ☐ C
- ☐ High blood pressure
- ☐ Intestinal problems
- ☐ Mental/nervous disorder
- ☐ MRSA
- ☐ Narcolepsy
- ☐ Pacemaker
- ☐ Parkinson's
- ☐ Pneumonia
- ☐ Poor leg circulation
- ☐ Prior nerve injury
- ☐ Psoriasis
- ☐ Pulmonary embolus
- ☐ Seizures
- ☐ Shortness of breath
- ☐ Sleep apnea
  - ☐ CPAP
  - ☐ BiPAP
- ☐ Sleep disorder
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Ulcers/reflux
- ☐ Other:_____

Review of Symptoms: *(Please check all that apply within the last 30 days)*

General:
- ☐ None
- ☐ Fever
- ☐ Unexplained falls
- ☐ Night sweats
- ☐ Weight change

Cardiovascular:
- ☐ None
- ☐ High blood pressure
- ☐ Chest pain/pressure
- ☐ Defibrillator
- ☐ Congestive heart failure
- ☐ Pacemaker

Circulation Problems:
- ☐ None
- ☐ Bleeding problems
- ☐ Phlebitis
- ☐ Poor leg circulation
- ☐ DVT (blood clot)

Neurologic/Psych:
- ☐ None
- ☐ Balance problems
- ☐ Memory loss
- ☐ Headaches/migraines
- ☐ Depression
- ☐ Numbness/tingling

Musculoskeletal:
- ☐ None
- ☐ Neck pain
- ☐ Back pain
- ☐ Joint problems
- ☐ Ankylosing spondylitis
- ☐ Osteoporosis
- ☐ Arthritis
  - ☐ Osteoarthritis
  - ☐ Rhematioid arthritis
- ☐ Gout

Respiratory:
- ☐ None
- ☐ On oxygen
- ☐ Shortness of breath
- ☐ Sleep apnea
  - ☐ CPAP
  - ☐ BiPAP
- ☐ Cough

Genitourinary Problems:
- ☐ None
- ☐ Bladder/kidney infection
- ☐ Prostate problem
- ☐ Dialysis
- ☐ Kidney stones

Head, Eyes, Ears, Nose,Throat:
- ☐ None
- ☐ Cataracts/cataract surgery
- ☐ Glaucoma
- ☐ Glasses/contacts
- ☐ Ringing in ears
- ☐ Sore throat
- ☐ Dentures/partials

Stomach/Digestive:
- ☐ None
- ☐ Blood in stool/black stools
- ☐ Irritable bowel syndrome
- ☐ Liver problems
- ☐ Ulcer/Reflux

Glandular:
- ☐ None
- ☐ Thyroid problems
  Type:_____
- ☐ Diabetes
  - ☐ Oral meds
  - ☐ Insulin
  - ☐ Diet
- ☐ Sterioid Use
  Condition: _____

X _____

Patient Signature Date

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