NORTHWEST
ORTHOPAEDIC
SPECIALISTS
Delivering Excellence

Medical History

DATE: ___/___ /_____

NAME:____________________________________ ☐ **Male** ☐ **Female** **DATE OF BIRTH:** ___/___ /_____

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

If injury, how did this occur? ______________________________

Have you had an X-ray, MRI, Nerve Conduction Study, or other testing for this problem? ☐ No ☐ Yes

Please describe what study, where, and when the study was done. ______________________________

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:

☐ Penicillin, reaction: ________________ ☐ Codeine, reaction: ________________ ☐ Latex, reaction: ________________

☐ Sulfa, reaction: ________________ ☐ Oxycodone, reaction: ________________ ☐ Tapes, describe: ________________

☐ Iodine Contrast, reaction: ________________ ☐ Hydrocodone, reaction: ________________ ☐ 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**

PERSONAL / SOCIAL HISTORY:

☐ Student ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Residence: ☐ Alone ☐ With family ☐ With friends ☐ Nursing home ☐ Retirement home ☐ Other: ____________

Employed: ☐ No ☐ Yes Occupation: ______________________________

Children: ☐ No ☐ Yes How many? ______________________________

If female, pregnant? ☐ No ☐ Yes

Smoking / tobacco history: ☐ I do not smoke or use tobacco ☐ Cigarettes ___ packs a day for ___ years ☐ Cigars ___ years

☐ Marijuana Smokeless tobacco: ☐ Patches ☐ Chewing tobacco ☐ E-cigarettes ___ years

Quit Smoking or tobacco use ☐ I quit smoking/tobacco. What year did you quit? ________________

Alcohol Consumption: ☐ I do not drink ☐ Rarely ☐ Occasionally ☐ Daily

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

Do you exercise? ☐ No ☐ Yes, what type? ________________

Have you ever had: Influenza (flu) immunization ☐ Yes ☐ No Pneumococcal (pneumonia) vaccine ☐ Yes ☐ No

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: ____

SURGICAL HISTORY:

Have you had general anesthetic?* ☐ No ☐ Yes Reaction? ☐ No ☐ Yes, Describe ____________________

Have you had a blood transfusion in the past? ☐ No ☐ Yes Reaction? ☐ No ☐ Yes ____________________

Have you had malignant hyperthermia?* ☐ No ☐ Yes

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 ☐ Tonsillectomy ☐ Gallbladder ☐ Bypass / Heart surgery, when? ____________________

☐ Hysterectomy ☐ Oophorectomy ☐ C-section ☐ Angioplasty / Stent, when? ____________________

☐ Hernia ☐ Mastectomy ☐ Varicose Veins

Other surgeries not listed above: ____________________

____

FAMILY HISTORY: ☐ **NONE**

☐ Excessive bleeding ☐ Blood clotting disorder ☐ Heart Disease ☐ Diabetes ☐ Malignant hyperthermia*

☐ Osteoporosis ☐ Problems with anesthesia, describe: ____________________

Other (specify): ____________________

REVIEW OF SYMPTOMS: *(Please check all that apply within the last 30 days)*

General: ☐ **NONE**

☐ Fever
☐ Unexplained falls
☐ Night sweats
☐ Weight change

Stomach / Digestive: ☐ **NONE**

☐ Blood in stool / black stools
☐ Irritable bowel syndrome
☐ Liver problems
☐ Ulcer / Reflux*

Genitourinary Problems: ☐ **NONE**

☐ Bladder / kidney infection
☐ Prostate problem
☐ Dialysis
☐ Kidney stones

Circulation Problems: ☐ **NONE**

☐ Bleeding problems
☐ Phlebitis
☐ Poor leg circulation
☐ DVT (blood clot)

Neurologic / Psych: ☐ **NONE**

☐ Balance problems
☐ Memory loss
☐ Headaches / migraines
☐ Depression
☐ Numbness / tingling

Cardiovascular: ☐ **NONE**

☐ High blood pressure*
☐ Chest pain / pressure*
☐ Defibrillator*
☐ Congestive heart failure
☐ Pacemaker*

Head, Eyes, Ears, Nose, Throat: ☐ **NONE**

☐ Cataracts / cataract surgery
☐ Glaucoma
☐ Glasses / contacts
☐ Ringing in ears
☐ Sore throat
☐ Dentures / partials*

Respiratory: ☐ **NONE**

☐ On oxygen
☐ Shortness of breath*
☐ Sleep apnea* ☐ CPAP* ☐ BiPAP*
☐ Cough

Musculoskeletal: ☐ **NONE**

☐ Neck pain
☐ Back pain
☐ Joint problems
☐ Ankylosing spondylitis
☐ Osteoporosis
☐ Arthritis
  ☐ Osteoarthritis ☐ Rheumatoid arthritis
☐ Gout

Glandular: ☐ **NONE**

☐ Thyroid problems
  Type: ____________________
☐ Diabetes
  ☐ Oral meds ☐ Insulin ☐ Diet
☐ Steroid Use
  Condition? ____________________

**Denotes Anesthesia Review*

x ____________________

Patient / Guardian's Signature Date

Northwest Orthopaedic Specialists, PS, complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.