



Orthopedics International

Medical History - Please Print

Please use Black ink

Name _____ D.O.B. _____ Age _____ Sex Male Female

Height _____ Weight _____ Primary Care Physician _____

Chief Complaint _____ Side of body _____ Onset Date _____

Have you ever had any problems with surgery or anesthesia? _____

DO YOU OR HAVE YOU EVER HAD

	Yes	No	Explain		Yes	No	Explain
Heart Trouble				Bad Teeth			
High blood pressure				Hearing Problems			
Stroke				Ulcer			
Blood Clots				Bladder Infections			
Anemia				Kidney Problems			
Bleeding Problems				Liver Problems			
Cancer				Hepatitis			
Asthma				Gout			
Emphysema				Thyroid Problems			
Tuberculosis				Seizures			
Diabetes				Psychiatric Care			
Glaucoma				Depression			
Arthritis				Prostate Problems			
Sleep Apnea				Other			

ARE YOU

Aware of any change in your general health in the recent past?.... Yes No
 Aware of any weight change?..... Yes No
 Pregnant (if female) Yes No If yes, # of months _____
 Taking birth control pills or hormones Yes No
 HIV Positive Yes No Unknown

DO YOU

Have a family history of diabetes, cancer, heart disease or other disease Yes No
 SmokeYes No If yes, how much? _____ How long? _____
 Drink alcohol ...Yes No If yes, how much? _____ How long? _____

Allergies & Reactions: a) _____ b) _____ c) _____

Previous Operations & Dates: Please use the back for additional space

a) _____ d) _____
 b) _____ e) _____
 c) _____ f) _____

Medications: Please use the back for additional space

a) _____ d) _____
 b) _____ e) _____
 c) _____ f) _____

Patient Signature _____

Date _____

Physicians Signature _____

Date _____