

## MEDICAL HISTORY

Name \_\_\_\_\_ Date \_\_\_\_\_

**What is the main reason that you have made this appointment?** \_\_\_\_\_

Drug **ALLERGIES** (hives, rashes, vomiting or unable to breathe): Which medications can't you take?

Medication	Reaction	Medication	Reaction

Habits: Do you smoke now or have you been a smoker? NO YES (please complete below)

\_\_\_\_\_ Packs per day For \_\_\_\_\_ years. I quit \_\_\_\_\_ years ago.

Do you drink alcohol? NO YES (please complete below)

\_\_\_\_\_ Drinks per week How frequently \_\_\_\_\_

Do you use recreational drugs? NO YES (please complete below)

What types? \_\_\_\_\_ How often? \_\_\_\_\_

Past medical history: If you, or anyone in your family have had any of these medical problems, please circle the appropriate answer:

	<u>You</u>		<u>Family</u>			<u>You</u>		<u>Family</u>	
Asthma	Yes	No	Yes	No	High Blood Pressure	Yes	No	Yes	No
Shortness of Breath	Yes	No	Yes	No	Bleeding Tendencies	Yes	No	Yes	No
Emphysema/COPD	Yes	No	Yes	No	Stroke/TIA	Yes	No	Yes	No
Other Lung Disease	Yes	No	Yes	No	Osteoporosis/Fractures	Yes	No	Yes	No
Tuberculosis/Exposure	Yes	No	Yes	No	Chronic Neck/Back Pain	Yes	No	Yes	No
Sleep Apnea/Snoring	Yes	No	Yes	No	Poor Leg Circulation	Yes	No	Yes	No
Hepatitis/Liver Disease	Yes	No	Yes	No	Rheumatoid Arthritis	Yes	No	Yes	No
Kidney Disease	Yes	No	Yes	No	Diabetes	Yes	No	Yes	No
Stomach Ulcers/Reflux	Yes	No	Yes	No	Thyroid Trouble	Yes	No	Yes	No
Angina/Chest Pain	Yes	No	Yes	No	Cancer Of Any Kind	Yes	No	Yes	No
Prostate Problems	Yes	No	Yes	No	AIDS/HIV Positive	Yes	No	Yes	No
Difficulty Urinating	Yes	No	Yes	No	Steroids/Prednisone	Yes	No	Yes	No
Heart Disease/Problems	Yes	No	Yes	No	Alcoholism	Yes	No	Yes	No
Poor Circulation	Yes	No	Yes	No	Depression	Yes	No	Yes	No
Neuropathy	Yes	No	Yes	No	Blood Clots	Yes	No	Yes	No
Heart Attack	Yes	No	Yes	No	Seizures	Yes	No	Yes	No
Heart Failure	Yes	No	Yes	No	Multiple Sclerosis	Yes	No	Yes	No
Rheumatic Fever	Yes	No	Yes	No	MRSA	Yes	No		

**OVER**

Name \_\_\_\_\_ Date \_\_\_\_\_

Past surgical history: Please indicate if you have had any of the following surgeries

Heart Bypass	Yes	No	
Other Heart Surgery	Yes	No	
Hip Replacement	Yes	No	
Other Hip Surgery	Yes	No	
Knee Replacement	Yes	No	
Other Knee Surgery	Yes	No	
Other Surgery	Yes	No	_____
			_____

Additional surgery information:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**If you are having a knee or hip replacement, describe your living situation:**

Do you live with anyone?	Yes	No
Do you have friends and/or family to assist you after surgery?	Yes	No
Do you have assistance with transportation?	Friend	Spouse No
Do you need to go to a skilled nursing facility after surgery?	Yes	No
If so, which facility is your preference? _____		
	(Fairview, Highland House, Royal Gardens, Other)	
Who is your dentist? _____	City	_____

**If you are here for a pre-operative visit, please answer the following:**

If you are a woman, when was your last menstrual period? \_\_\_\_\_

Are you or could you be pregnant? \_\_\_\_\_