

## MEDICAL HISTORY:

**Patient Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

*(Enter a check by the answer that applies)*

**How would you describe your general health?**

Excellent  Good  Fair  Poor

**MARITAL STATUS:**

Single-never married  
 Married  
 Widowed  
 Separated  
 Divorced

**WORK STATUS**

Full time  
 Part time  
 Retired  
 Disabled

**Do you currently smoke?**  Yes  No  
**Have you smoked in the past?**  Yes  No  
**If yes, when did you stop?** \_\_\_\_\_

**Do you use alcohol regularly?**  Yes  No  
**Have you used alcohol in the past?**  Yes  No

**Do you have any allergies?** (If yes, please list below)

\_\_\_\_\_  
\_\_\_\_\_

**Are you currently taking any medication?** (If yes, list below)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Have any of the following diseases or conditions occurred in your immediate (parents or siblings) family?** (If yes, please check the ones that apply).

- |   |  |
|---|--|
| 1. <input type="checkbox"/> Heart Disease | 5. <input type="checkbox"/> Diabetes                   |
| 2. <input type="checkbox"/> Arthritis     | 6. <input type="checkbox"/> Blood disorders            |
| 3. <input type="checkbox"/> Cancer        | 7. <input type="checkbox"/> Kidney failure             |
| 4. <input type="checkbox"/> Stroke        | 8. <input type="checkbox"/> Previous Joint Replacement |

**Do you have any religious or other reasons to refuse a blood transfusion if it became necessary with surgery?**  Yes  No

PLEASE CHECK YES AND INDICATE THE YEAR FOR ANY OF THE FOLLOWING PROCEDURES THAT YOU HAVE HAD.

YEAR	YES
	Appendectomy
	Tonsillectomy
	Back Surgery
	Neck Surgery
	Heart Surgery
	Balloon Angioplasty
	Pacemaker
	Stent Placement
	Heart Bypass
	Heart Valve Replacement
	Other Heart Surgery
	Bladder Surgery
	Prostate Surgery
	Kidney Stone Surgery
	Cataract Surgery
	Intestinal Surgery
	Gall Bladder Surgery
	Gastric Bypass

YEAR	YES
	Brain Surgery
	C-Section
	Hysterectomy
	Mastectomy
	Other Breast Surgery
	Kidney Surgery
	Hernia Surgery
	Vascular Surgery
	Carotid Artery Surgery
	Vein Stripping
	Thyroid Surgery
	Knee Arthroscopy
	Other Knee Surgery
	Hip Surgery
	Shoulder Surgery
	Other Orthopedic Surgery
	Other Surgery

DO YOU CURRENTLY HAVE, OR HAVE YOU BEEN TREATED IN THE PAST, FOR ANY OF THE FOLLOWING CONDITIONS? (Place a check under NOW or PAST, as indicated).

NOW	PAST	CONDITION	NOTES	NOW	PAST	CONDITION
		<b>METABOLIC:</b>				<b>CARDIOVASCULAR:</b>
		Diabetes				High blood pressure
		Low blood sugar				Chest pain
		Thyroid disease				Heart Attack
		Gout				Congestive heart failure
		Osteoporosis				Irregular heartbeat
		<b>CANCER: (List type below)</b>				Heart valve disease
						Aortic valve stenosis
						Mitral valve prolapse
		<b>SKIN:</b>				Fast heartbeat
		Boils				Other heart problems
		Severe rashes				Elevated Cholesterol
		Psoriasis				Varicose veins
		Non-healing wounds				Carotid Artery Disease
		<b>EYES:</b>				Coronary Artery Disease
		Cataracts				Peripheral Vascular Disease
		Loss of vision				
		Glaucoma				<b>BLOOD:</b>
						Bleeding problems
		<b>EARS:</b>				Hemophilia
		Hearing loss				Prior blood transfusions
		Hearing aids				Blood clots in veins
		Buzzing/ringing				

NOW	PAST	CONDITION	NOTES	NOW	PAST	CONDITION
		<b>RESPIRATORY:</b>				
		Asthma				
		Bronchitis				
		Chronic cough				<b>STOMACH/BOWEL:</b>
		Emphysema				Reflux
		Shortness of breath				Ulcer disease
		Wheezing				Pancreatitis
		Sinus trouble				Crohn's disease
		Nose bleeds				Ulcerative colitis
		Sleep apnea				Other colitis
		<b>NEUROLOGIC:</b>				Liver disease
		Chronic headaches				Malnutrition / Malabsorption
		Fainting				Gall bladder problems
		Seizures (epilepsy)				Diverticulosis / Diverticulitis
		Numbness				
		Foot Drop				<b>URINARY:</b>
		Stroke				Frequent urination
		Severe head injury				Incontinence
		Alzheimer's				Kidney failure
		Dementia				Kidney stones
		Parkinson's disease				Kidney/bladder infection
		Paralysis				Prostate trouble
		Carpal Tunnel Syndrome				Night time urination
		Tremor				
		<b>PSYCHOLOGICAL:</b>				<b>INFECTIONS:</b>
		Depression				HIV / AIDS
		Bipolar / Manic depressive				Hepatitis
		Trouble sleeping				Herpes
		Nervous				Tuberculosis
		Nervous breakdown				Syphilis
		Drug use or dependence				Wound infection
		Alcohol abuse or dependence				Rheumatic fever
		Chronic pain syndrome				Malaria
		<b>MUSCULOSKETETAL:</b>				<b>BONE FRACTURES:</b>
		Bone or joint infection				Arm
		Paget's disease				Leg
		Perthes disease				Spine
		Neck pain				Pelvis
		Back pain				Hip
		Sciatica				Other
		Rheumatoid Arthritis				
		Ankylosing Spondylitis				
		Systemic Lupus				
		Fibromyalgia				

**NOTES:**

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