

The Orthopedic Center, P.A.
Patient's Personal History

Patient's Name: _____

Date: _____

Confidential Record: Information contained here will not be released except when you have authorized us to do so. Please answer all questions to the best of your knowledge. The information provided by you will be used by your doctor in his decision regarding your care.

Please list any medical conditions you have:

Please list all surgeries you have had and dates:

Please list all medication you are presently taking with dosage:

PLEASE LIST ALL ALLERGIES TO MEDICATIONS:

Family History: (circle positives only)

Rheumatoid arthritis, osteoarthritis, heart disease, bleeding disorders, endocrine problems, muscle disease, neurological disease, diabetes.

Social History: Single _____ Married _____ Children _____ (ages) _____

Living Situation: _____

Tobacco: Yes _____ packs per day
No _____ Were you ever a smoker? _____

Alcohol Drinks per _____ day _____ week _____ month

Employment with job description:

The following is a list of medical conditions. If you/the patient have one of these conditions please **circle it**. The list is long, but it is important that the doctor knows this information.

- GENERAL:** Weight GAIN / LOSS (purposeful/not purposeful)
EYES: Glaucoma / change in vision (explain) _____
ENT: Deafness Dizziness Hay fever Nosebleeds Sinus problems Bleeding Gums
Cardiac: Palpitations Congenital heart disease Rheumatic heart disease Chest pain Hypertension
RESPIRATORY: Shortness of breath Asthma Bronchitis Lung disease Cough Pneumonia Tuberculosis
GI: Diarrhea Constipation Blood from Rectum Inflammatory Bowel Disease
Black stools Hepatitis Jaundice Ulcers
GU: Bladder Infections Kidney disease Blood in urine Renal insufficiency Kidney stones
GYN: Excessive menstruation Missed periods Pregnancy
MUSCULOSKELETAL: Arthritis Gout Joint pain- location _____
SKIN: Rashes Lesions Masses Eczema Dermatitis Melanoma
NEUROLOGICAL: Numbness Weakness Seizures Memory Loss
EMOTIONAL DISORDER: Attention Deficit Depression Addiction
ENDOCRINE: Thyroid problems Diabetes Goiter
HEMATOLOGY: Bleeding disorders Anemia Leukemia

CANCER:

Height: _____ Weight: _____

SIGNATURE: _____ DATE: _____