ADVANCED ORTHOPEDICS
MEDICAL HISTORY

All sections must be completed. If not applicable, please indicate as "N/A".

Last Name _____ First Name _____ M.I. _____ ☐Male ☐Female

Date Of Birth _____/_____/_____ Age_____

Primary Physician (provide first & last name)_____ Height_____ Weight_____

MEDICAL HISTORY (Check yes or no. Provide details to all yes answers)

Yes	*No*	*Details Medication*
☐	☐	High Blood Pressure_____
☐	☐	Heart Problems/Pacemaker/Chest Pain_____
☐	☐	Diabetes_____
☐	☐	Cancer_____
☐	☐	Asthma/Lung Disease/Shortness of Breath_____
☐	☐	Hepatitis/Liver Disorders_____
☐	☐	Thyroid Problems_____
☐	☐	Bleeding Problems/Stroke_____
☐	☐	Blood Clots/Phlebitis_____
☐	☐	Kidney Disease_____
☐	☐	Frequent Bladder Infections_____
☐	☐	Stomach Ulcer/Bleeding_____
☐	☐	Depression/Mental Illness_____
☐	☐	H.I.V._____
☐	☐	Ear, Nose, Throat, Mouth Problems_____
☐	☐	Seizure_____
☐	☐	Osteoporosis_____
☐	☐	Numbness/Tingling_____
☐	☐	Other Illness/Hospitalization_____
		_____
☐	☐	Previous Bone or Joint Problems_____
		_____
☐	☐	Other Sports Injury_____

DRUG ALLERGIES (check yes or no)

Yes	*No*	
☐	☐	If yes, provide details_____
		_____

MEDICATIONS (current/recent)

Name of Med.	*Dosage*	*Frequency*

REVIEW OF SYSTEMS

Yes	*No*	
☐	☐	**PREVIOUS SURGERY** (type and dates)_____
		_____
☐	☐	**FAMILY HISTORY** (illness, reactions to anesthesia) _____
		_____
☐	☐	**RECENT TEST RESULTS** (EKG, chest x-ray, blood or HIV tests, etc.)_____
		_____
☐	☐	**RECENT ILLNESSES OR SYMPTOMS** _____
		_____
☐	☐	**SMOKE?** (pack/day)_____
☐	☐	**DRINK?** (how often?)_____

WOMEN ONLY

Pregnant? _____

Birth Control (type) _____

NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person, except when you have authorized us to do so. I have read and answered completely and accurately.

SIGNATURE: _____ DATE: _____