COMPREHENSIVE ORTHOPAEDICS & MUSCULOSKELETAL CARE, L.L.C.
MEDICAL HISTORY FORM

NAME___________________________________ DATE___________________________
AGE________________ HEIGHT______________ WEIGHT______________
PRIMARY CARE DOCTOR____

SOCIAL HISTORY

Do you smoke?_____________________
How many packs per day?___________
Do you drink alcohol or beer?_________
How much?________________________

Marital status_____________________
Occupation________________________
Females, are you pregnant?___________

PRESENT MEDICAL HISTORY

Do you have any allergies to drugs or latex? Yes__________ No__________
If yes, please list the medication and the reaction:_____________________________________
____
____

List the name/dosage of any medications you are presently or have recently taken:
None__________
____
____

What is your dominant hand?_____________________

PAST MEDICAL HISTORY

Have you ever seen an orthopaedic surgeon?__________ If so, for what?___________________
List all past operations and any adverse reactions to anesthesia: None_____________________
____
____

Have you ever had a blood transfusion? ______ Have you ever taken a cortisone drug? ______
Have you ever been treated for or had any indications of:

Past	Present		Past	Present	
____	_____	Diabetes	____	_____	Sexually transmitted disease
____	_____	Asthma	____	_____	Liver disease
____	_____	High blood pressure	____	_____	Varicose veins
____	_____	Mental/Emotional disorders	____	_____	Ulcers
____	_____	Cancer	____	_____	Kidney disease
____	_____	Lung disease	____	_____	Heart disease
____	_____	Bleeding tendencies	____	_____	Rheumatic fever/Heart murmur
____	_____	Thyroid or glandular problems			

FAMILY HISTORY

Do you have a family history of:

_____ Heart disease _____Stroke _____High blood pressure
_____ Liver disease _____Diabetes _____Thyroid disease
_____ Kidney disease _____Bleeding tendencies _____Anesthesia complications
_____ Cancer – Location____
_____ Other diseases____

PATIENT SIGNATURE______________________________ DATE_____________________