

Name \_\_\_\_\_

Date \_\_\_\_\_

## Medical History Questionnaire

Please complete this medical history form to the best of your ability. If you need assistance, ask the assistant that brings you to the exam room for help. Please print clearly.

<b>Allergies?</b>	<b>Medication</b>	<b>Reaction</b>	<b>Medication</b>	<b>Reaction</b>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If more space is needed, please continue list on back of page.

### Medications

<b>Name</b>	<b>Dose</b>	<b>Frequency</b>	<b>Name</b>	<b>Dose</b>	<b>Frequency</b>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

If more space is needed, please continue list on back of page.

**Herbal Supplements?** Please list any herbal supplements that you take.

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### Medical History and Review of Systems

#### General symptoms

- Weight gain \_\_\_\_\_ lbs
- Weight loss \_\_\_\_\_ lbs
- Fevers
- Chills
- Night sweats

#### Ear, Nose Throat

- Hearing loss
- Visual problems
- Headache

#### Cardiovascular System

- High blood pressure
- Heart attack
- Chest pain
- Arrhythmia
- Circulation problems
- High cholesterol
- Heart failure
- Heart murmur
- Other \_\_\_\_\_

#### Pulmonary Disease

- Shortness of breath
- Asthma
- Emphysema
- Other \_\_\_\_\_

#### Gastrointestinal Disease

- Diarrhea
- Constipation
- Hepatitis **A B C** (circle one)
- Ulcers, acid reflux, GERD

#### Urinary Disorders

- Incontinence Stress?
- Prostate
- Other \_\_\_\_\_

#### Skin

- Psoriasis
- Eczema

#### Endocrine

- Diabetes
- Thyroid Disease

#### Neuro/Psych

- Stroke
- Seizure
- Depression
- Anxiety
- Other \_\_\_\_\_

#### Musculoskeletal

- Arthritis/Rheumatism
- Gout
- Osteoporosis
- Fractures \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

#### Cancer

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Name \_\_\_\_\_

Date \_\_\_\_\_

### Past Surgical History

Procedure	Date	Procedure	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If more space is needed, please continue list on back of page.

### Family History

	Father	Mother	Siblings
Deceased? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart failure _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____			

### Surgical Risks

- Latex Allergy ?  Yes  No
- Blood Transfusion?  Yes  No
- Reaction ?  Yes  No
- Reaction to Anesthesia ?
  - Personal  Yes  No
  - Family  Yes  No
- History of Blood Clots ?
  - Legs  Yes  No
  - Lungs  Yes  No

### Social History

Tobacco: Cigarettes \_\_\_\_\_ packs/day \_\_\_\_\_ yrs Alcohol: Type \_\_\_\_\_ amnt/freq \_\_\_\_\_

Recreational drugs Yes No Type? \_\_\_\_\_

Living Situation (Circle answer) Home Other \_\_\_\_\_ Family Alone

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Working? Yes No Last Date Worked \_\_\_\_\_

Education: Highest level of education completed \_\_\_\_\_

Sports/Hobbies \_\_\_\_\_

By signing this form, I certify the information provided is accurate and correct to the best of my knowledge.

Signature \_\_\_\_\_ Date \_\_\_\_\_

TRI COUNTY ORTHOPEDIC SURGEONS, INC.

Privacy Communication Worksheet

Designated person(s) to whom we may share protected health information:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date: \_\_\_\_\_ Initial \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date: \_\_\_\_\_ Initial \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date: \_\_\_\_\_ Initial \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

Signature Patient/Legal Guardian: \_\_\_\_\_

Print Patient Name: \_\_\_\_\_

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