

Bone & Joint Medical Center

Name: _____

Date of Birth: ____/____/____ Age: _____ Height: _____ Weight: _____

Occupation: _____

Personal Medical History (Please circle any and all that apply to yourself)

Cardiovascular

Chest Pain
Hypertension
Elevated Cholesterol
Heart Disease
Obesity
Stroke

Neurological

Headaches
Head Injury
Dizziness
Seizures
Numbness and Tingling
Meningitis
Fibromyalgia

Integumentary

Eczema
Psoriasis
Hives
Excessive Bruising
Rash
Lupus

Respiratory

Cough
Shortness of Breath
Chest Pain when Breathing
Bronchitis
Asthma
Pulmonary embolism
Tuberculosis
Emphysema

Eyes

Glaucoma
Cataracts
Glasses
Contacts

Musculoskeletal

Arthritis
Osteoarthritis
Rheumatoid arthritis
Gout
Joint Pain
Stiffness
Swelling
Osteoporosis
Broken Bones
Osteogenesis imperfecta
Osteomalacia
Rickets

Hematological/Lymphatic

Blood Transfusion
Blood clots
Anemia
Bleeding Disorders

Immunological/ Infectious

Hepatitis
HIV/AIDS

Please list others that you feel are significant

Gastrointestinal

Ulcer
Gallbladder disease
Hepatitis
Colitis
Hernia
Laxative use

Cancer

Lung
Liver
Gallbladder
Colon
Rectal
Bladder
Bone
Breast
Ovarian
Other _____

Endocrine

Hypothyroidism
Hyperparathyroidism
Diabetes

Social History (please circle one)

Single

Married

Divorced

Widowed

Do you have any children? Yes / No

If yes how many _____

Do you currently smoke? Yes / No

If yes how many packs per day and for how long have you smoked _____

Do you currently exercise regularly or participate in a sport? Yes / No

If yes please list the activity or sport and tell how frequently you participate _____

Please list your previous surgeries, orthopedic and non-orthopedic; (include year performed and procedure)

Family History (please circle if any blood relative, not yourself, has had any of the following)

Heart Disease (coronary artery disease)
Stroke
Cancer
Bleeding disorder
Arthritis
Neurologic/Psychiatric disorder

Diabetes
Epilepsy
Thyroid Disease
Lung Disease
Osteoporosis
Osteogenesis imperfecta

Current Medications (please list all medications that you are currently taking *with the dosages*)

Allergies (please list any allergies to medications or other substances)

I hereby certify that I have reviewed the above medical history and that it is accurate to my knowledge at this time. If there are any future changes in the above information, I will inform the above stated Institute of same.

X _____
Patient or Guardian signature Date

X _____
Patient or Guardian Signature Date