OPAORTHO
ORTHOPEDIC PHYSICIAN ASSOCIATES

PATIENT MEDICAL HISTORY

PATIENT NAME: _____
LAST FIRST MIDDLE INITIAL

DATE OF BIRTH: ____ /____ /_____ GENDER: ☐ MALE ☐ FEMALE AGE: _____ HEIGHT: _____ WEIGHT: _____

OCCUPATION: _____ RETIRED? ☐ NO ☐ YES

PRIMARY CARE PHYSICIAN: _____ REFERRED BY: _____

Is this a work related injury? ☐ NO ☐ YES

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ WIDOW/ER ☐ DEPENDENT ☐ DOMESTIC PARTNER

RACE: ☐ WHITE/CAUCASIAN ☐ BLACK/AFRICAN AMERICAN ☐ NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER ☐ ASIAN
☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ PREFER NOT TO DISCLOSE ☐ UNKNOWN ☐ OTHER _____

ETHNICITY: ☐ HISPANIC OR LATINO ☐ NOT HISPANIC OR LATINO ☐ PREFER NOT TO DISCLOSE ☐ UNKNOWN

PREFERRED LANGUAGE: _____

PERSONAL MEDICAL HISTORY

(Please check if YOU currently have or had the following diseases/conditions and check any that apply.)

☐ GLAUCOMA
☐ EPILEPSY/SEIZURES/CONVULSIONS
☐ STROKE/TIA
☐ HIGH BLOOD PRESSURE
☐ HEART PROBLEMS/HEART ATTACK/ IRREGULAR HEARTBEAT
☐ DVT/PULMONARY EMBOLISM/ BLOOD CLOTS
☐ ANEMIA/BLEEDING DISORDER
☐ ASTHMA/COPD/EMPHYSEMA/ BREATHING PROBLEMS
☐ DIABETES
☐ THYROID DISORDER
☐ LIVER DISEASES/HEPATITIS TYPE: _____
☐ KIDNEY DISEASE/KIDNEY STONES
☐ PROSTATE DISEASE
☐ ARTHRITIS
☐ GOUT
☐ OSTEOPOROSIS/OSTEOPENIA
☐ CANCER TYPE: _____
☐ COMMUNICABLE DISEASES
☐ TUBERCULOSIS
☐ ANTIBIOTIC RESISTANT INFECTION/ MRSA
☐ ANXIETY/DEPRESSION
☐ HIV
☐ STEROID USE
☐ METAL ALLERGY
☐ ANESTHESIA DIFFICULTIES/ MALIGNANT HYPERTHERMIA
☐ CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP)
☐ OTHER: _____
☐ NONE

PREVIOUS SURGERIES

(Please list ALL previous surgeries and date.)

PROCEDURE/DATE	PROCEDURE/DATE
1. _____	6. _____
2. _____	7. _____
3. _____	8. _____
4. _____	9. _____
5. _____	10. _____

MEDICATIONS

(Please list ALL medications including prescriptions, over-the-counter medications and blood thinning medications such as Coumadin, Plavix, aspirin, etc.)

MEDICATION	DOSE	HOW OFTEN
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

ALLERGIES

(Please list ALL allergies including contrast dyes, metal, latex, medication or other.)

NAME	SPECIFY REACTION (hives, rash, breathing difficulty, anaphylaxis)
1.	
2.	
3.	
4.	
5.	

FAMILY MEDICAL HISTORY

(Please check if anyone in your FAMILY has or had the following diseases/conditions; check the applicable condition and state your relationship.)

- ☐ GLAUCOMA _____
- ☐ EPILEPSY/SEIZURES/CONVULSIONS _____
- ☐ HIGH BLOOD PRESSURE _____
- ☐ HEART PROBLEMS/HEART ATTACK/IRREGULAR HEARTBEAT/ STROKE _____
- ☐ DVT/PULMONARY EMBOLISM/BLOOD CLOTS _____
- ☐ ANEMIA/BLEEDING DISORDER _____
- ☐ ASTHMA/BREATHING PROBLEMS/EMPHYSEMA _____
- ☐ DIABETES _____
- ☐ THYROID DISORDER _____
- ☐ LIVER DISEASES/HEPATITIS, TYPE: _____
- ☐ KIDNEY PROBLEMS _____
- ☐ ARTHRITIS _____
- ☐ GOUT _____
- ☐ OSTEOPOROSIS/OSTEOPENIA _____
- ☐ CANCER, TYPE: _____
- ☐ METAL ALLERGY _____
- ☐ OTHER: _____
- ☐ NONE

SOCIAL HISTORY

Do you use tobacco? ☐ NO ☐ YES Packs Per Day: _____ If Quit, When: _____

Do you drink alcohol? ☐ NO ☐ YES How Much/Often: _____ If Quit, When: _____

Current or history of drug use? ☐ NO ☐ YES Type: _____ If Quit, When: _____

Are you pregnant? ☐ NO ☐ YES ☐ POSSIBLY

How many children do you have? _____ Number living with you? _____

REVIEW OF SYSTEMS

(Please check if YOU are experiencing any of the following symptoms and check any that apply.)

- ☐ FEVER
- ☐ WEIGHT LOSS OR GAIN
- ☐ CHILLS
- ☐ FATIGUE
- ☐ SORE THROAT
- ☐ DIFFICULTY SWALLOWING
- ☐ NOSE BLEEDS
- ☐ EAR OR HEARING PROBLEMS
- ☐ HEADACHE
- ☐ MIGRAINES
- ☐ EXCESSIVE THIRST OR APPETITE
- ☐ EXCESSIVE URINATION
- ☐ HEAT OR COLD INTOLERABLE
- ☐ VISUAL DIFFICULTY
- ☐ REDNESS
- ☐ WATERY EYES
- ☐ CHEST PAIN
- ☐ PALPITATIONS
- ☐ FAINTING
- ☐ MURMURS
- ☐ COUGH
- ☐ SPUTUM PRODUCTION
- ☐ SNORING
- ☐ SHORT OF BREATH
- ☐ WHEEZING
- ☐ BLOOD IN STOOL
- ☐ LOSS OF BOWEL CONTROL
- ☐ NAUSEA
- ☐ VOMITING
- ☐ ULCERS
- ☐ UROLOGICAL PROBLEMS
- ☐ PAINFUL URINATION
- ☐ PROSTATE PROBLEMS
- ☐ BLEEDING PROBLEMS
- ☐ EASY BRUISING
- ☐ JOINT SWELLING
- ☐ STIFFNESS
- ☐ HEAT
- ☐ MUSCLE PAIN
- ☐ SWELLING
- ☐ DEPRESSION
- ☐ NERVOUSNESS
- ☐ ANXIETY
- ☐ HALLUCINATIONS
- ☐ SKIN DISORDERS
- ☐ RASH
- ☐ POOR HEALING

The above information is true and correct to the best of my knowledge.

PATIENT SIGNATURE _____ DATE _____

M.D. REVIEW _____ DATE _____