OLYMPIA ORTHOPAEDIC ASSOCIATES

MEDICAL HISTORY FORM

Name: _____ Age: _____ Sex: _____ Height: _____ Weight: _____

Left or Right Handed? (circle) Occupation: _____ Primary Care Physician: _____

Medical History: Do you have or have you ever had: Please circle

A-fib	Y N	GI Disease / GERD	Y N	MRSA _____ *(year)*	Y N
Anemia	Y N	Glaucoma	Y N	Migraines / Headache	Y N
Angina	Y N	Gout	Y N	Pacemaker/Defib _____ *(year)*	Y N
Arthritis	Y N	HIV	Y N	Psoriasis	Y N
Asthma	Y N	Heart Attack _____ *(year)*	Y N	Rheumatoid Arthritis	Y N
Bleeding Disorder/Abnormality	Y N	Heart Disease	Y N	Seizures/Epilepsy	Y N
COPD / Emphysema	Y N	Hepatitis _____ (type)	Y N	Sleep Apnea / CPAP	Y N
Cancer _____ *(type)*	Y N	High Cholesterol	Y N	Stent Placement _____ *(year)*	Y N
DVT/Blood Clots _____ *(year)*	Y N	High Blood Pressure	Y N	Stomach Ulcers	Y N
Depression _____ *(year)*	Y N	Insulin	Y N	Stroke _____ *(year)*	Y N
Diabetes	Y N	Kidney Disease	Y N	Thyroid Condition	Y N
Fibromyalgia	Y N	Liver Disease	Y N	Tick Bites	Y N

Other medical conditions not listed above: _____

Current System Review: Do you currently experience any of the following problems? Please circle

Chest pain	Y N	Fever	Y N	Joint Swelling	Y N	Urinary Difficulty	Y N
Chills	Y N	Hay Fever	Y N	Memory Loss	Y N	Vision Problems	Y N
Constipation	Y N	Hearing Loss	Y N	Short of Breath	Y N	Wear Glasses	Y N
Diarrhea	Y N	Heartburn	Y N	Sinus Problems	Y N	Weight Loss	Y N
Difficulty Breathing	Y N	Joint Stiffness	Y N	Skin Problems	Y N	Wheezing	Y N

Family History: Any history of Cancer, Diabetes, Heart Disease, Bleeding Disorder, Blood Clots, Anesthetic Death or other Diseases?
If so, please include type and family relation. _____

_____

Prior Surgeries: (Type of surgery; date of surgery) _____

_____

Are You Taking Blood Thinners? Y N **Please circle:** Aspirin Coumadin/Warfarin Plavix Pradaxa Eliquis Xarelto Lovenox

All Other Current Medications: (Name of medication; Strength/dosage; How often taken)

_____

_____

_____

Do you have <u>any</u> medication allergies or reactions to pain medication? (Indicate medication and type of reaction)

_____

Do you have a history of substance abuse or alcoholism?_____

Do you have an allergy to Latex? Y N **Do you have an allergy to Metal/Jewelry?** Y N **Type of Metal**: _____

Smoking Y N How Much: _____ Date Quit: _____ **Alcohol Y N** How Much: _____

Who Lives With You? _____ # of Steps Inside Home: _____ # of Steps To Front Door: _____

Do you have Any Pets? _____ Type: _____ Do You Have a Living Will? _____

Patient Signature _____ Date: _____