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
- ☐ Other ________________
- ☐ Unknown

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 (List: ________________)
- ☐ 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.		

OVER →

PATIENT MEDICAL HISTORY

OPAortho™

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 (List: ____________)
- ☐ 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 ____________