Animas Orthopedic Associates

General Medical History Worksheet

Check boxes and fill in information as appropriate

Name: _____ Date of Birth: _____ Date: _____

Who are your primary doctor(s) to whom reports should be sent? _____

Past Medical History

☐ Diabetes/High Blood Sugar	☐ High Blood Pressure	☐Heart Attack/Heart Disease	☐ Lung Disease/Emphysema (explain): _____
☐ Arthritis	☐ Sleep Apnea	☐ Gout	☐ Prior Fractures/Broken Bones (explain): _____
☐ Varicose Veins	☐ Thyroid Disease	☐ Psychiatric Problems	☐ Inflammatory Arthritis (Rheumatoid, Lupus, Psoriatic)
☐ Fibromyalgia	☐ Stroke/T.I.A.	☐ High Cholesterol	☐ Bowel and GI Problems: (explain): _____
☐ Urinary Tract Infections	☐ Anemia/Hemophilia	☐Blood Clot/Deep Vein Thrombosis	☐Serious Infections (explain): _____
☐ HIV/AIDS	☐ Breast Disease	☐ Poor Circulation or Vascular Disease	☐ Sexually Transmitted Disease (explain): _____
☐ Prostate Disease	☐ Multiple Sclerosis	☐ Eating Disorder/Poor Nutrition	☐ Skin Disease (explain): _____
☐ Kidney Disease	☐ Anesthesia Problems	☐ Gastric Ulcers	☐Hepatitis ("Jaundice")/Liver Disease

Cancer History (type and current status): _____

Other Medical Problems: _____

Prior Hospitalizations and Surgical History

☐ No Past Medical History

	Type of Surgery/Reason for Hospitalization	Date	Surgeon/Physician
1.			
2.			
3.			
4.			
5.			

Current Medications (include herbal supplements and attach sheet if necessary)

☐ Taking No Medication

	Name of Medication	Dose/Strength	Schedule Taken
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Allergies to Medication or Materials

☐ No Known

	Allergen	Reaction
1.		
2.		
3.		

Social Background

Marital Status: ☐ Married ☐ Domestic Partnership ☐ Single ☐ Divorced ☐ Widowed

Age(s) of children: _____ Can someone care for you at home? ☐ No ☐ Yes, who? _____

Do you drink caffeinated beverages? ☐ No ☐ Yes If so, how much per day? _____

Do you have a history of illicit drug use? ☐ No ☐ Yes If so, explain: _____

Do you use tobacco? ☐ No ☐ Yes If so, how much/packs per day? _____ How many years? _____

Previously used tobacco? ☐ No ☐ Yes If so, did you quit ☐ 1 year ago ☐ >5 years ago ☐ >10 years ago

Do you drink alcohol? ☐ No ☐ Occasionally ☐ Daily How much? _____

Family Medical History

Relation	Age	State of Health	Age of Death	Medical Problems/Cause of Death
Mother				
Father				
Siblings ☐ Bro ☐Sis				
Siblings ☐ Bro ☐ Sis				
Siblings ☐ Bro ☐ Sis				
Grandfather (maternal)				
Grandmother (maternal)				
Grandfather (paternal)				
Grandmother (paternal)				

Review of Systems: Are you currently having or have you had a problem with:

Condition	Check a Box	Please Describe all "Yes" Responses
Fever or Shaking Chills	☐ No ☐ Yes	
Weight Loss (not diet related)	☐ No ☐ Yes	
Chest Pain	☐ No ☐ Yes	
Lung or Breathing Problems	☐ No ☐ Yes	
Irregular Heart Beat	☐ No ☐ Yes	
Problems Urinating	☐ No ☐ Yes	
Loss of Strength or Numb/Tingling	☐ No ☐ Yes	
Bowel or Stool Problems	☐ No ☐ Yes	
Headaches	☐ No ☐ Yes	
Vision Problems	☐ No ☐ Yes	
Skin Issues	☐ No ☐ Yes	
Pregnancy or Menstrual Problems	☐ No ☐ Yes	
Lumps or Masses (incl. breast)	☐ No ☐ Yes	
Fainting/Seizures/Blackout	☐ No ☐ Yes	
Bleeding or Blood Clots	☐ No ☐ Yes	
Psychiatric Issues	☐ No ☐ Yes	
Problems with Anesthesia	☐ No ☐ Yes	
Ears, Nose or Throat	☐ No ☐ Yes	

X_____ _____ X_____

Signature of Patient, Parent, of Guardian Date Reviewed by MD