MID-ATLANTIC ORTHOPAEDIC SPECIALISTS, P.C.

PATIENT SELF-HISTORY

Allergies (Medications)	Reaction
Allergic to: [ ]Latex [ ]Betadine	

Current Medications [ ] NONE	Dose	How often

Please check all that apply:

Dominant Hand: [ ]Right [ ]Left

Height________________ Weight________________

Family Physician

____

Previous illnesses, injuries or surgeries:

____
____
____
____
____
____
____
____
____
____
____

Any problems with anesthesia: (self, family)
[ ]No [ ]Yes If Yes, explain____________________
____
____

Information obtained from:
[ ]Patient [ ]Family [ ]Other

[ ]Previously intubated or ventilated
[ ]Asthma
[ ]Bronchitis
[ ]Pneumonia
[ ]Emphysema/COPD
[ ]Tuberculosis
[ ]Abnormal chest x-ray
[ ]Shortness of breath
[ ]Angina
[ ]Heart attack
[ ]Congestive heart failure
[ ]High blood pressure
[ ]Low blood pressure
[ ]Heart murmur
[ ]Abnormal EKG
[ ]Dysrhythmia
[ ]Pacemaker
[ ]Mitral valve prolapse
[ ]Syncope
[ ]Malnutrition
[ ]Hepatitis
[ ]Jaundice
[ ]Kidney disease
[ ]Dialysis: [ ]Hemo [ ]PD
[ ]Kidney stones
[ ]Urinary tract infection
[ ]Blood clots
[ ]Excessive/easy bleeding/bruising
[ ]Varicose veins

[ ]Stroke
[ ]Paralysis
[ ]Multiple sclerosis
[ ]Seizures
[ ]Headaches
[ ]Mental health
[ ]Closed head injury
[ ]Gallbladder
[ ]Hiatal hernia
[ ]Hernia
[ ]Ulcers
[ ]GI bleeding
[ ]Crohn's disease
[ ]Ulcerative colitis
[ ]Diverticulitis
[ ]Hemorrhoids
[ ]History of falling (Date of last fall) _________________
[ ]Arthritis
[ ]Joint replacement
[ ]Gout
[ ]Diabetes
[ ]Hypoglycemia
[ ]Anemia
[ ]Sickle cell anemia
[ ]Cancer
[ ]Chemo/Radiation
[ ]MRSA
[ ]Sleep apnea

Patient Name: ____

Date of Birth: __________________________ Age_____________

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PATIENT SELF-HISTORY

Please check all that apply:

Respiratory: [ ]Shortness of breath—When______________________ [ ]Chronic/frequent cough [ ]Cold
[ ]Wheezing [ ]Productive cough with color

Heart: [ ]Chest pain/pressure/angina—How often__________________ [ ]Ankle swelling
[ ]Sleep with more than 1 pillow [ ]Irregular heart beat

Neurological: [ ]Fainting [ ]Dizziness [ ]Confusion [ ]Numbness [ ]Weakness arm/leg

Stomach/Bowel: [ ]Nausea [ ]Vomiting—How often________________ [ ]Heartburn [ ]Belching [ ]Thirst
[ ]Diarrhea [ ]Constipation [ ]Blood in vomit/stool [ ]Good appetite [ ]Recent weight gain

Urinary: [ ]Blood [ ]Pain [ ]Trouble holding [ ]Discharge [ ]Trouble starting [ ]Frequency [ ]Get up at night
[ ]Last prostate exam_________________________

Skin/Muscle/Joint: [ ]Neck/Back pain [ ]Stiffness [ ]Leg ulcers [ ]Leg pain or cramps [ ]Rash [ ]Dry skin
[ ]Sweating [ ]Metal/Plastic parts (metal rods, hip replacement) [ ]Other prosthesis—type_______________

Eye, Ear, Nose, Throat: [ ]Change in vision [ ]Spots before eyes [ ]Double vision [ ]Ringing in ears [ ]Hoarseness
[ ]Decreased hearing [ ]Eye/Ear drainage [ ]Nose bleeds [ ]Sore mouth [ ]Frequent sore throats

Habits: Tobacco use: [ ]Cigarettes—#packs______ per day for ______ years Quit smoking, when_________________________
[ ]Cigars/pipe [ ]Smokeless tobacco [ ]Coffee Alcohol use: [ ]Never [ ]Rarely [ ]Weekly [ ]Daily
Drug use: [ ]Never [ ]Rarely [ ]Weekly [ ]Daily

FAMILY HISTORY: Has any member of your family had any of the following illnesses: (State who had it.)

Allergies	Deafness	High blood pressure
Anemia or bleeding tendencies	Diabetes	Kidney disease
Arthritis or gout	Glaucoma or blindness	Muscular dystrophy
Cancer (of what organ)	Heart attack by age 50	Tuberculosis
		Other

If living—state age and health of relative. If deceased, state cause of death and age relative died.

Father	Brother(s)	Sister(s)
Mother		

For Clinical Use Only

Height ___________

Weight ___________

Temp ____________

____

Clinical Reviewer **Date**

____

Patient (Parent or Legal Guardian) Signature **Date**