VALLEY BONE & JOINT Medical History

NAME_____

Birth Date_____ Age_____ Height_____ Weight_____

PAST MEDICAL HISTORY : (Please check all that apply)

__Bleeding Disorders	__Venous Insufficiency	__Diabetes
__High Blood Pressure	__Heart Attack	__AIDS
__Coronary Artery Disease	__Stroke	__Glaucoma
__Asthma	__Emphysema	__Pneumonia
__Chronic Bronchitis	__Tuberculosis	__Hepatitis
__Kidney Disorders	__Thyroid Disorders	__Arthritis
__Rheumatic Fever	__Anxiety/Depression	__Reflux Disease/Ulcers
__Cancer	__Sexually Transmitted Diseases	
__Other: _____	_____	_____
_____	_____	_____

MEDICATIONS _____

ALLERGIES _____

PAST SURGICAL HISTORY:

YEAR	PROCEDURE	LOCATION / SURGEON

Have you ever had problems associated with anesthesia during surgery?
If yes, please explain.

_____

SOCIAL HISTORY: Occupation? _____

Marital Status: M S D Do you have children? Yes / No If yes, how many?_____

Who do you live with? _____

Do you smoke? Yes / No How many packs per day? _____ How many years? _____

Do use alcohol? Yes / No If yes, how much and what type? _____

Do you use drugs? Yes / No Do you use steroids? Yes / No

(Over →)

REVIEW OF SYSTEMS

Have you had, or are you having problems with any of the following:

GENERAL HEALTH

Weight Change	Yes / No
Fever / Chills	Yes / No
Night Sweats	Yes / No
Fatigue	Yes / No

HEENT

Visual Changes	Yes / No
Headaches	Yes / No
Hearing Changes	Yes / No
Glasses	Yes / No
Dentures	Yes / No

HEART / RESPIRATORY

Chest Pain	Yes / No
Irregular Heart Beats	Yes / No
Cough	Yes / No
Shortness of Breath	Yes / No
Difficulty Breathing	Yes / No

SKELETAL

Joint Swelling	Yes / No
Joint Pain	Yes / No
Stiffness	Yes / No

ENDOCRINE

Thyroid Disorders	Yes / No
Excessive Thirst	Yes / No

HEMATOLOGIC

Anemia	Yes / No
Bleeding	Yes / No

GASTROINTESTINAL

Appetite Changes	Yes / No
Diarrhea	Yes / No
Constipation	Yes / No
Nausea / Vomiting	Yes / No

GENITOURINARY

Urinary Infections	Yes / No
Incontinence	Yes / No
Venereal Disease	Yes / No
Burning with Urination	Yes / No
Frequent Urination	Yes / No

NEUROLOGIC

Seizures	Yes / No
Numbness	Yes / No
Weakness	Yes / No
Dizzy / Faint	Yes / No
Poor Balance	Yes / No

PSYCHOLOGICAL

Poor Sleep	Yes / No
Anxiety	Yes / No
Depression	Yes / No

SKIN

Rashes / Itching	Yes / No
Skin Ulcers	Yes / No

FAMILY HISTORY:

	Living	Age	Present Health / Cause of Death
Father	Yes / No	_____	_____
Mother	Yes / No	_____	_____
Brothers	Yes / No	_____	_____
Sisters	Yes / No	_____	_____
Children	Yes / No	_____	_____

Check all illnesses that have occurred in your blood relatives :

__Anesthesia Problems	__Diabetes	__Cancer	__AIDS
__Osteoarthritis	__Rheumatoid Arthritis	__Severe Allergy	__Bleeding Disorders
__High Blood Pressure	__Stroke	__Heart Disease	__Kidney Disorders
__Seizure Disorders	__Other_____		

Signature_____ Date_____