Inland Orthopaedic Surgery & Sports Medicine Clinic
MEDICAL HISTORY

Please take some time to fill out this history. All information is held with strict confidentiality and is released only with your written permission.

Patient Name _____ Birthdate _____ (mm/dd/yyyy) Today's Date _____ (mm/dd/yyyy)

Reason for seeing Orthopaedic Physician today:

_____

_____

WHICH SIDE? ☐ Right ☐ Left Date of injury, if applicable: _____

Pharmacy: _____

Current Medications & Dosages:

_____

_____

Allergies: _____

Family Physician: _____

Previous Hospitalizations/surgeries and date occurred: _____

Check YES or NO IF YOU, PRESENT OR PAST, HAVE EVER EXPERIECED:

	Yes	No		Yes	No
High Blood Pressure	☐	☐	Epilepsy-Seizures	☐	☐
Heart Disease	☐	☐	Psychiatric Illness	☐	☐
Heart Murmur	☐	☐	Depression	☐	☐
Lung Disease	☐	☐	Thyroid Problems	☐	☐
Tuberculosis	☐	☐	Abdominal Pain, etc	☐	☐
Asthma	☐	☐	Diabetes	☐	☐
Blood Clots	☐	☐	Urinary Problems	☐	☐
Abdominal Bleeding	☐	☐	Cancer	☐	☐
Blood Transfusions	☐	☐	Hepatitis – Jaundice	☐	☐

Please list any on-going medical problems you might have: _____

FAMILY HISTORY (Check YES or NO): **IF YES, PLEASE LIST WHOM:**

	Yes	No	
Alcoholism	☐	☐	_____
Bleeding Disorder	☐	☐	_____
Cancer	☐	☐	_____
Diabetes	☐	☐	_____
Heart Disease	☐	☐	_____
High Blood Pressure	☐	☐	_____
Kidney Disease	☐	☐	_____
Osteoporosis	☐	☐	_____
Stroke	☐	☐	_____

PERSONAL HABITS (Check YES or NO): **IF YES:**

	Yes	No	
Drink Alcohol?	☐	☐	# of drinks per week: _____
Smoke?	☐	☐	# per day _____ for how long? _____
Used Drugs?	☐	☐	List type & date last used: _____
Had an eating disorder?	☐	☐	Describe _____
Had Problems Sleeping?	☐	☐	Describe _____
Exercise?	☐	☐	List type & frequency: _____
Caffeine?	☐	☐	Amount per day: _____