Premier Orthopedics Medical History Form

Name: _____ Age: _____ Ht: _____ Wt: _____

Are you right or left handed? Right Left Ambidextrous

Current Occupation: _____ Date: _____

Past Surgical History

Date	Type of surgery and, if extremity, which extremity

Current Medical Problems

Date	Current medical condition

Current Medications, including dose and frequency

Allergies

Are you allergic to any medications? ☐ Yes ☐ No

If so, please list: _____

Habits

Smoking Usage and History			**Alcohol Usage and History**		
☐ None	☐ <1/2 pack/day	☐ 1 pack/day	☐ None	☐ <1 drink/week	☐ 3 drinks/week
☐ >1 pack/day	☐ 2 packs/day	☐ >2 packs/day	☐ 7 drinks/week	☐ 1-2 drinks/day	☐ >2 drinks/day
Quit, Last smoked			Quit drinking in:		
Are you now or have you in the last 12 months used:			**Do you have, or had, a dependency problem with:**		
Narcotic pain medication	☐Yes ☐No		Narcotic pain medication	☐Yes ☐No	
Marijuana (including medical)	☐Yes ☐No		Marijuana (including medical)	☐Yes ☐No	
Illegal street drugs (cocaine, crack, etc.)	☐Yes ☐No		Illegal street drugs (cocaine, crack, etc.)	☐Yes ☐No	
Intravenous drugs	☐Yes ☐No		Intravenous drugs	☐Yes ☐No	
Prescription medications not listed above	☐Yes ☐No		Prescription medications not listed above	☐Yes ☐No	

Exercise, Sports, Hobbies

How often do you exercise? ☐Daily ☐3 times/week ☐1-2 times/week ☐Once a week ☐< Once a week

List any sports you play _____

List any hobbies you have _____

Current / Past / Family History

Please review the following medical conditions and note if A) You have this condition currently B) Have had this condition in the past or C) Know of a family member who has had this condition. Please check Yes or No for each

	Current Condition	Past Condition	Present in Family Members
High Blood Pressure	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Heart Disease	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Bronchitis/Asthma/Emphysema	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Sleep Apnea	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Stroke	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Peripheral Vascular Disease	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Neuropathy	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Kidney Disease	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Malignant Hyperthermia	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Immune Deficiency Disorder	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Hepatitis	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Blood Clots	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Review of Systems

Do you have any of these symptoms? Please check Yes or No for each

Constitutional
Depression ☐Yes ☐No
Weight Loss / Gain ☐Yes ☐No
Fever or Chills ☐Yes ☐No

Musculoskeletal
Joint Swelling ☐Yes ☐No
Muscle Aches ☐Yes ☐No
Joint Pain ☐Yes ☐No
Fibromyalgia ☐Yes ☐No

Heart
Chest Pain ☐Yes ☐No
Irregular Heartbeat ☐Yes ☐No
Poor Circulation ☐Yes ☐No

Respiratory
Shortness of Breath ☐Yes ☐No
Wheezing ☐Yes ☐No
Asthma ☐Yes ☐No

Gastrointestinal
Stomach Pain ☐Yes ☐No
Diarrhea ☐Yes ☐No
Reflux ☐Yes ☐No
Ulcers ☐Yes ☐No

Endocrine Function
Diabetes ☐Yes ☐No
Thyroid Problems ☐Yes ☐No
Osteoporosis ☐Yes ☐No
Malignant Hyperthermia ☐Yes ☐No

Skin
Dryness of Skin ☐Yes ☐No
Rashes or Psoriasis ☐Yes ☐No

Hematopoietic/Lymph
Easy Bruising/Bleeding ☐Yes ☐No
Extremity Swelling ☐Yes ☐No
Anemia ☐Yes ☐No

Neurologic
Numbness in Hands/Feet ☐Yes ☐No
Muscle Weakness ☐Yes ☐No

Immunologic
Frequent Infections ☐Yes ☐No
Viral Infections ☐Yes ☐No

Do you know that you now are, or could possibly be, pregnant? ☐ Yes ☐ No ☐ Not applicable

Anesthesia History

Have you or any family members ever had a major problem with anesthesia?

Yourself ☐ NO ☐ YES Describe Reaction: _____

Family Members ☐ NO ☐ YES Describe Reaction: _____

Physician Review

Today's Date	Physician's Initials	Physician Notations

Patient Name _____