EVANGELISTA ORTHOPEDIC CLINIC

Name: _____DOB_____ HT____ ft _____ in WT_____

What are you seeing the doctor for today: _____

_____

Date of injury or onset of problem: _____ Affected side: Left Right

Have you had x-rays taken? □ Yes □ No If yes, where? _____

Have you had an MRI? □ Yes □ No If yes, where? _____

Previous Physician(s) you have seen for this problem? _____

_____

MEDICAL HISTORY Current and past medical problems (please circle)

Anemia	Asthma	Neurological Disorder/Seizures	High Cholesterol
Diabetes	COPD	Depression	High Blood Pressure
Thyroid Disorder	Arthritis	Anxiety	Heart Trouble
Kidney Trouble	Fibromyalgia	AIDS/HIV	Stroke
Bladder Issues	Phlebitis/Blood Clots	Substance Abuse	Sleep Apnea
Ulcer/Stomach Problems	Gout	Hepatitis (Type)	Cancer (Type)
Other:			

SURGICAL HISTORY ☐ None

Procedure	Month/Year

HOSPITALIZATION ☐ None

Reason	Month/Year

MEDICATIONS ☐ NONE

List all current prescription, non-prescription medications, vitamins, and herbal products. INCLUDE even occasional use of aspirin or anti-inflammatory medication.

Name	Dosage/Strength	Times/day

ALLERGIES ☐ NONE

INCLUDE allergies to medications and other medical products (examples: tape, latex, and iodine).

Name of Medicine or Product:	Description of Reaction:

FAMILY HISTORY

Please list any major medical conditions and if they are deceased or alive.

Father:_____

Mother:_____

Siblings:_____

Has any blood relative younger than 50 ever had unusual bleeding tendencies? ☐ NO ☐ YES

If yes, Who and what is their age: _____

Have you or any blood relative, younger than 50, ever had a serious reaction to anesthesia? ☐ NO ☐ YES

If yes, who and what is their age? _____

SOCIAL HISTORY

Do you now or have you ever smoked? ☐ NO ☐ YES

If yes, how long?_____ How often?_____ Year quit?_____

Do you drink alcohol? ☐ NO ☐ YES

If yes, average consumption a week? _____

Do you now or have you ever used drugs? ☐ NO ☐ YES

If yes, explain: _____