MEDICAL HISTORY

TEXAS ORTHOPAEDIC ASSOCIATES

PATIENT INFO

FIRST NAME: LAST NAME: DATE OF BIRTH:

AGE: HEIGHT (FT/IN): WEIGHT (LBS): FAMILY PHYSICIAN:

PAST MEDICAL HISTORY

HAVE YOU EVER HAD ANY OF THE FOLLOWING?:
Check all that apply

- ☐ Arthritis
- ☐ Rheumatoid arthritis
- ☐ Heart attack
- ☐ Heart disease
- ☐ Lung disease
- ☐ Liver disease
- ☐ Kidney disease
- ☐ Thyroid disease
- ☐ Diabates
- ☐ Cancer
- ☐ Blood clots
- ☐ Hepatitis
- ☐ Seizures
- ☐ Ulcers
- ☐ Gout
- ☐ HIV/AIDS
- ☐ Stroke
- ☐ Sleep Apnea
- ☐ High Blood Pressure
- ☐ Blood Transfusions
- ☐ Bleeding Disorders
- ☐ Asthma
- ☐ MRSA
- ☐ Organ Transplant
- ☐ Other:

PAST SURGICAL HISTORY

PLEASE LIST ANY SURGERIES YOU HAVE HAD AND APPROXIMATELY WHEN IT WAS PERFORMED:

OPERATION	YEAR	OPERATION	YEAR

ANY COMPLICATIONS FROM SURGERY?:

○ No ○ Yes If Yes, please explain:

HAVE YOU OR ANY ONE IN YOUR FAMILY EXPERIENCED ANY ANESTHESIA COMPLICATIONS?:

○ No ○ Yes If Yes, please explain:

MEDICATIONS

PLEASE LIST THE MEDICATIONS YOU TAKE REGULARLY AND THEIR DOSAGES:

MEDICATION	DOSE	MEDICATION	DOSE

DO YOU HAVE ANY MEDICATION ALLERGIES?:

○ No ○ Yes If Yes, please list :

FAMILY HISTORY

PLEASE LIST ANY SIGNIFICANT FAMILY MEDICAL HISTORY:

SOCIAL HISTORY

ARE YOU CURRENTLY:

☐ Single ☐ Married ☐ Employed ☐ Unemployed

Occupation:

DO YOU: Check all that apply

- ☐ Smoke cigarettes How many packs per day?:
- ☐ Smoke cigars
- ☐ Other tobacco products
- ☐ Drink alcohol Average how many drinks per day?: