

OLYMPIA ORTHOPAEDIC ASSOCIATES MEDICAL HISTORY FORM

Name _____ Today's Date _____

Age _____ Sex: M or F (circle) Height _____ Weight _____ Are you: left or right handed (circle)

Occupation _____ Primary Care Physician _____

Past Medical History: Do you have or have you ever had: *Please circle*

High Blood Pressure	Y N	Hepatitis	Y N	Sleep Apnea	Y N	Cancer	Y N
Diabetes	Y N	Do you take insulin?	Y N	Heart Disease	Y N	Angina	Y N
Arthritis	Y N	Stroke	Y N	MRSA	Y N	Asthma	Y N
Thyroid Condition	Y N	Stomach Ulcers	Y N	GI Disease	Y N	Gout	Y N

Other Medical Conditions not listed above:

Prior Surgeries: (Type of surgery; date of surgery)

Present Medications: (Name of medication; Strength / dosage; How often taken)

Are you taking blood thinners? Y N Please circle: Coumadin Plavix Warfarin Aspirin

Medication Allergies: (Indicate medication and type of reaction)

Do you have an allergy to Latex? Y N

Habits: Smoking Y N How Much? _____ Alcohol Y N How Much? _____

Family History: Is there a family history of Diabetes, Heart Disease, Cancer, other diseases?

System Review: Do you experience any of the following problems? *Please circle*

Fever	Y N	Chills	Y N	Weight Loss	Y N	Vision Problems	Y N
Wear Glasses	Y N	Hearing Loss	Y N	Sinus Problems	Y N	Chest pain	Y N
Difficulty Breathing	Y N	Short of Breath	Y N	Heartburn	Y N	Diarrhea	Y N
Constipation	Y N	Urinary Difficulty	Y N	Joint Stiffness	Y N	Joint Swelling	Y N
Skin Rashes	Y N	Skin Problems	Y N	Seizures	Y N	Memory Loss	Y N
Depression	Y N	Diabetes	Y N	Anemia	Y N	Blood Disorders	Y N
Hay Fever	Y N	Wheezing	Y N				

Patient Signature _____ Reviewed by _____ Date _____
Reviewed by _____ Date _____
Reviewed by _____ Date _____

