

Pontchartrain Bone & Joint Clinic Medical History Questionnaire

(Please Print)

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Past Medical History (please check all that apply)

	Illness/Injury		Illness/Injury
	High blood pressure		Asthma
	Diabetes		Lung disease (please specify _____)
	Heart attack		Kidney disease (please specify _____)
	Heart problems (please specify _____)		Liver disease (please specify _____)
	Ulcers, stomach or intestinal		Previous anesthesia problems
	Stroke (when _____)		Thyroid problems
	Cancer (please specify _____)		Blood clots/DVT's
	Hepatitis		Bleeding tendency
	HIV/AIDS		Osteoporosis
	Arthritis		Females: Are you or could you be pregnant
	Rheumatologic disease		
	Gout		Other: _____

Past Surgical History (please list previous surgeries)

	Date	Type of Operation	Complication/problems
1			
2			
3			
4			
5			
6			
7			
8			

Please list any current medications

Drug	Dosage and frequency	Drug	Dosage and frequency
1)		6)	
2)		7)	
3)		8)	
4)		9)	
5)		10)	

Do you take blood thinners? yes no

Do you have any drug allergies? yes no

If yes, please list.

Drug	Reaction	Drug	Reaction
1)		5)	
2)		6)	
3)		7)	
4)		8)	

Please list any other allergies (e.g. egg, iodine, latex). _____

Doctor's Notes:

Social History

Do you use tobacco?	<input type="checkbox"/> no	<input type="checkbox"/> yes, # of packs/day ____ # of years ____
Did you use tobacco?	<input type="checkbox"/> no	<input type="checkbox"/> yes, when did you quit? _____
Do you drink alcoholic beverages?	<input type="checkbox"/> no	<input type="checkbox"/> yes, what type and how often _____
Are you: <input type="checkbox"/> single <input type="checkbox"/> married <input type="checkbox"/> divorced <input type="checkbox"/> widowed		

Family History (please list any family problems that apply)

Illness/Injury	Illness/Injury
Heart Disease	Rheumatoid arthritis
Diabetes	Gout
High blood pressure	Degenerative arthritis
Cancer (please specify _____)	Immunologic disorder
Anesthesia problems	Other: _____

Review Of Systems (please check any recent problems)

Constitutional symptoms	Gastrointestinal	Neurological
Recent weight change	Loss of appetite	Frequent Headaches
Fever	Nausea or vomiting	Light headed or dizzy
Unexplained sweating	Frequent diarrhea	Seizures
Eyes	Constipation	Numbness or tingling
Wear glasses or contacts	Blood in stool or rectal bleeding	Tremors
Blurry or double vision	Black tarry stools	Paralysis
Glaucoma	Abdominal pain or heartburn	Psychiatric
Ear ,Nose, Throat	Genitourinary	Memory loss or confusion
Hearing Loss	Frequent urination	Anxiety
Regular nose or gum bleeding	Burning or painful urination	Insomnia
Sore throat	Blood in urine	Depression
Swollen glands in the neck	Incontinence or dribbling	Endocrine
Cardiovascular	Female: ____ # of pregnancies	Glandular or hormone problem
Irregular heart beats	Female: ____ # of miscarriages	Excessive thirst or urination
Shortness of breath	Musculoskeletal	Heat or cold intolerance
Chest pain	Joint pain	Changes in hair or nails
Swelling in the feet, ankles, or hands	Joint stiffness and swelling	Hematology
Fainting spells	Morning stiffness	Bleeding or bruising tendency
Respiratory	Difficulty walking	Anemia
Chronic or frequent coughing	Muscle cramping	History of blood transfusion
Spitting up blood	Integumentary	
Emphysema	Rash or itching	Height _____
Wheezing	Changes in skin color	Weight _____
	Varicose veins	

Patient Signature (or parent/guardian if patient is a minor) _____ Date _____

Doctor:

I certify that I have reviewed the information on this form.

Doctor Signature	Date	Doctor Signature	Date	Doctor Signature	Date