Coral Desert Orthopaedics

Date: _____

PATIENT MEDICAL HISTORY

Patient Name (Last – First – Middle Initial)	Age	Weight lbs.	Height Ft In

Who is your primary/family doctor?	If you were referred to this clinic by another doctor please list the doctor's name here.

Allergies

☐ None/No Known Allergies ☐ Adhesive Tape ☐ Anesthesia ☐ Aspirin ☐ Codeine
☐ Iodine/Shellfish/Contrast Dye ☐ Latex ☐ Morphine ☐ Penicillin ☐ Sulfa Drugs

OTHER:

FAMILY HISTORY – Please indicate if any of your immediate relatives have had any of the following by placing an X in the appropriate box.

	MOTHER	FATHER	SIBLING (Brother/Sister)
Anesthesia Problems			
Arthritis			
Cancer			
Diabetes			
Heart Problems			
Hypertension			
Stroke			

SOCIAL HISTORY

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Occupation: _____ ☐ Retired ☐ Disabled (reason _____)

☐**Yes** ☐**No** - Do you drink alcohol? ☐ Daily ☐Weekly ☐Infrequently ☐ Recovering Alcoholic

☐**Yes** ☐**No** - Do you use tobacco? ☐ Smoke (___ packs per day) ☐ Chew

Surgical History: Please list any hospitalizations, surgeries, fractures or major illnesses you have had.

TYPE OF SURGERY	YEAR or DATE	DOCTOR	LOCATION

Medical History: Have you ever had any of the following?

☐ NONE of the problems listed ☐ CAD coronary artery disease ☐ drug/alcohol abuse ☐ migraines/headaches
☐ allergies ☐ cancer ☐ fibromyalgia ☐ neuropathy
☐ anemia ☐ chest pain ☐ heart disease ☐ pulmonary embolism/blood clot in legs
☐ arthritis conditions ☐ CHF congestive heart failure ☐ hypertension ☐ seizure disorders
☐ asthma ☐ depression ☐ infection problems ☐ shortness of breath
☐ bleeding problems ☐ diabetes ☐ kidney problems

Medications: List any medications you are currently taking (please include over the counter medications):

PLEASE PRINT LEGIBLY – NO CURSIVE PLEASE

PREFERRED PHARMACY: _____

MEDICATION	DOSAGE	PERSCRIBING DOCTOR