

**CURRENT AND PAST HISTORY (Please Print)**

Date \_\_\_\_\_

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Chief Complaint \_\_\_\_\_

Right/Left (Please Circle) \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Date of Injury \_\_\_\_\_ (Please Circle) @ Work/Sports/Home/Auto/No Known  
Litigation Yes/No

EMPLOYMENT STATUS: \_\_\_ Student \_\_\_ Working  
\_\_\_ Full-time \_\_\_ Part-time \_\_\_ Retired \_\_\_ Disabled

JOB DESCRIPTION: \_\_\_\_\_

SMOKING HISTORY: \_\_\_ Never \_\_\_ Previously \_\_\_ Packs/Day for \_\_\_ yrs/mos  
Quit \_\_\_ yrs/mos \_\_\_ Currently \_\_\_ Packs/Day for \_\_\_ yrs/mos

ALCOHOL: \_\_\_ Beers/Wine per day \_\_\_ oz of alcohol/day ADDICTING DRUGS: \_\_\_\_\_

**ALLERGIES AND MEDICATION INTOLERANCE**

ALLERGIES	MEDICATION AND REACTION
Describe any previous adverse reactions to anesthesia or blood transfusions:	

**CURRENT MEDICATIONS AND DOSAGES (INCLUDE NON-PRESCRIPTION & HERBAL SUPPLEMENTS)**

Medication	Dose	Medication	Dose

**PAST SURGICAL HISTORY**

Surgery	Year	Surgery	Year

Appendectomy, angioplasty, colonoscopy, cardiac catheterization, hysterectomy, tonsillectomy, etc.  
(Please circle all that apply)

**PLEASE COMPLETE OTHER SIDE**

<b>Fracture History:</b>				
<b>System Review</b>	<b>Circle all that apply</b>	<b>Yes</b>	<b>No</b>	<b>Comments</b>
<b>Eyes, Ears</b>	Contacts, metal in eyes, cataracts, glaucoma, loss of hearing			
<b>Psychological</b>	Depression, anxiety			
<b>Respiratory</b>	Asthma, emphysema, bronchitis, shortness of breath			
<b>Cardiovascular</b>	High blood pressure, heart attack, chest pain, palpitations, blood clots, high cholesterol, swelling (lower extremities)			
<b>Gastrointestinal</b>	Abdominal pain, nausea/vomiting, constipation, diarrhea, colitis, ulcer, gall bladder, pancreatitis			
<b>Genitourinary</b>	Urinary tract infection, renal disease/failure, incontinence, sexually transmitted disease Female: pregnant, post menopausal			
<b>Endocrine</b>	Thyroid disease, diabetes			
<b>Integumentary</b>	Rash			
<b>Neurological</b>	Stroke, poliomyelitis, migraines, numbness, tingling			
<b>Musculoskeletal</b>	Joint pain, back pain, neck, sciatica, fibromyalgia, rheumatoid arthritis, osteoarthritis, lupus, osteoporosis			
<b>Hematological</b>	Hepatitis, HIV, mononucleosis, bleeding disorders    Blood Type_____			
<b>Cancer History</b>	Please List:			

**FAMILY HISTORY**

<b>Family Member</b>	<b>Living</b>	<b>Age(s)</b>	<b>Medical History</b>
Father			
Mother			
Brother(s)			
Sister(s)			

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Physician Signature** \_\_\_\_\_ **Date** \_\_\_\_\_