slocum orthopedics, p.c.

MEDICAL HISTORY

Today's Date: _____

Name: _____

Date of Birth: _____ Age: _____

Health History
Entered By: _____
Date: ___ /___ /___

For Office Use Only

Referring Doctor _____ PCP/Family Doctor _____

Chief Complaint: Reason for Doctor Visit: _____Date of Injury: _____

Race: Please check the most correct category:
☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino
☐ Multiracial ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Other: _____
☐ Prefer not to answer

Preferred Language: ☐English ☐Other: _____

Ethnicity: Please check the most correct category:
☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer not to answer

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Partnered

Allergies/Reaction: *If you do not have any allergies to list please check* ☐**NONE**
(Medications, metals, and chemicals)
Allergy: **Reaction:**
_____
_____
_____

Current Medications: *If you are not currently taking any medications please check* ☐**NONE**
Med: **Dose:** **Directions (sig):**
_____
_____
_____
_____
_____
_____

Past Medical History: *Please check all that apply or check* ☐**NONE**

☐ AIDS/HIV
☐ Alcoholism
☐ Alzheimer's (Dementia)
☐ Anemia
☐ Anesthetic Problems
☐ Asthma
☐ Blood Clots\DVT
☐ Cancer: _____
☐ COPD (Lung Disease)
☐ CVA (Stroke)
☐ Depression
☐ Diabetes
☐ Drug Abuse
☐ Fibromyalgia
☐ Gout
☐ Healing Problems
☐ Heart Disease
☐ Hepatitis: ____
☐ High Blood Pressure
☐ High Cholesterol
☐ Hypothyroidism
☐ Kidney Disease
☐ Osteoarthritis
☐ Osteoporosis
☐ Pacemaker
☐ Peptic Ulcer Disease
☐ Peripheral Vascular Disease
☐ Reflux
☐ Rheumatoid Arthritis
☐ Seizure
☐ Sleep Apnea
☐ Other: _____

☐ **No Medical History**

PLEASE TURN OVER AND COMPLETE THE OTHER SIDE

Name: _____

Past Surgical History: *Please list any past surgical history or check* ☐NONE

Surgery: **Year:**

_____
_____
_____
_____
_____

☐ **No Surgical History**

Family History: *Please check all that apply or check* ☐NONE

Father ☐NONE	**Mother** ☐NONE	**Siblings** ☐NONE	**Children** ☐NONE	**Other** ☐NONE
☐Anesthetic Problems	☐Anesthetic Problems	☐Anesthetic Problems	☐Anesthetic Problems	☐Anesthetic Problems
☐Bleeding Problems	☐Bleeding Problems	☐Bleeding Problems	☐Bleeding Problems	☐Bleeding Problems
☐Blood Clots/DVT	☐Blood Clots/DVT	☐Blood Clots/DVT	☐Blood Clots/DVT	☐Blood Clots/DVT
☐Cancer: _____	☐Cancer: _____	☐Cancer: _____	☐Cancer: _____	☐Cancer: _____
☐Diabetes	☐Diabetes	☐Diabetes	☐Diabetes	☐Diabetes
☐Gout	☐Gout	☐Gout	☐Gout	☐Gout
☐Heart Disease	☐Heart Disease	☐Heart Disease	☐Heart Disease	☐Heart Disease
☐High Blood Pressure	☐High Blood Pressure	☐High Blood Pressure	☐High Blood Pressure	☐High Blood Pressure
☐Osteoarthritis	☐Osteoarthritis	☐Osteoarthritis	☐Osteoarthritis	☐Osteoarthritis
☐Other:_____	☐Other:_____	☐Other:_____	☐Other:_____	☐Other:_____

☐**No Significant History**

Social History:

Drug Use / Abuse: ☐Yes ☐No
Former Use: ☐Yes ☐No
Type: _____

Tobacco Use: ☐Yes ☐No ☐Former
Type: ☐Chew ☐Cigarettes ☐Cigar ☐Pipe
Amount/day: _____
Years of use: _____

Alcohol: ☐Yes ☐No
Former Use: ☐Yes ☐No
Amount/Frequency: _____
Type: _____

What is your smoking status? ☐Never smoked ☐Unknown if ever smoked ☐Former smoker
☐Smoker, current status unknown ☐Current occasional smoker ☐Current every day smoker

☐ Right-handed ☐Left-handed ☐ Ambidextrous

Activity Level: ☐Sedentary ☐Moderate ☐Vigorous

Exercise Freq: ☐Never ☐ Occasional ☐ 2-3 times/week
☐ 3-4 times/week ☐ Daily

Occupation: _____