BALLARD ORTHOPEDIC & FRACTURE CLINIC

PATIENT MEDICAL HISTORY

NAME (Please Print) _____ AGE _____

SEX: M F HEIGHT _____ WEIGHT _____ HANDED: R L

NAME OF DOCTOR _____

MEDICATIONS: Please list medications along with dosages. [ ] None

_____

_____

_____

MEDICATIONS ALLERGIES: Please list all allergies to medications. [ ] None

_____

PREVIOUS SURGERIES: Please list all previous surgeries. [ ] None

_____

HAVE YOU EVER HAD ANY PROBLEMS WITH SURGERY OR ANESTHESIA?

[ ] None [ ] Yes. Please Describe. _____

_____

_____

DO YOU SMOKE? [ ] No [ ] Yes. How Much? _____

DO YOU DRINK ALCOHOL? [ ] No [ ] Yes. How Much? _____

DO YOU HAVE NOW OR HAVE EVER HAD:

	Past Problem	Current Problem	Never		Past Problem	Current Problem	Never
Anemia	[ ]	[ ]	[ ]	Glaucoma	[ ]	[ ]	[ ]
Arthritis	[ ]	[ ]	[ ]	Gout	[ ]	[ ]	[ ]
Asthma	[ ]	[ ]	[ ]	Heart Problems	[ ]	[ ]	[ ]
Bad Teeth	[ ]	[ ]	[ ]	High Blood Pressure	[ ]	[ ]	[ ]
Bladder Infection	[ ]	[ ]	[ ]	Kidney Disease	[ ]	[ ]	[ ]
Bleeding Problems	[ ]	[ ]	[ ]	Liver Disease	[ ]	[ ]	[ ]
Blood Clots	[ ]	[ ]	[ ]	Psychiatric Treatment	[ ]	[ ]	[ ]
Cancer	[ ]	[ ]	[ ]	Stomach Ulcers	[ ]	[ ]	[ ]
Depression	[ ]	[ ]	[ ]	Stroke	[ ]	[ ]	[ ]
Diabetes	[ ]	[ ]	[ ]	Thyroid Disorders	[ ]	[ ]	[ ]
Emphysema	[ ]	[ ]	[ ]	Tuberculosis	[ ]	[ ]	[ ]
Epilepsy	[ ]	[ ]	[ ]	Other Illnesses	[ ]	[ ]	[ ]

ARE YOU:

Pregnant	[ ] No	[ ] Yes	Other Illnesses	[ ] No [ ] Yes
Presently Being Treated for Any Illness				[ ] No [ ] Yes
Aware of Any Change in Your General Health in the Past Year				[ ] No [ ] Yes
Aware if Any Recent Weight Change				[ ] No [ ] Yes

The above information is true and correct to the best of my knowledge.

Signature _____ **Date** _____