

MEDICAL HISTORY

Last Name: _____ First Name: _____ MI: _____

MEDICAL CONDITIONS (Please check all current and old diagnosis):

	Yes	No		Yes	No
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Cancer or Tumor	<input type="checkbox"/>	<input type="checkbox"/>
Heart Valve Problem	<input type="checkbox"/>	<input type="checkbox"/>	Positive H.I.V. (AIDS)	<input type="checkbox"/>	<input type="checkbox"/>
Lung Problem	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Any Joint Implants?	<input type="checkbox"/>	<input type="checkbox"/>
Liver Problem	<input type="checkbox"/>	<input type="checkbox"/>	Do you smoke? (Packs/Day:)	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Problem	<input type="checkbox"/>	<input type="checkbox"/>	Do you drink Alcohol?	<input type="checkbox"/>	<input type="checkbox"/>
Stomach Problem	<input type="checkbox"/>	<input type="checkbox"/>	Do you use street drugs?	<input type="checkbox"/>	<input type="checkbox"/>
Intestine Problem	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Do you take antibiotics prior to surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Blood Clotting Problem	<input type="checkbox"/>	<input type="checkbox"/>
Broken Foot or Ankle If yes, explain _____	<input type="checkbox"/>	<input type="checkbox"/>	<i>Female Patient:</i> Is there a possibility of you being pregnant today?	<input type="checkbox"/>	<input type="checkbox"/>

Other medical condition(s) not listed here: _____

List hospitalizations/surgeries in past: _____

ALLERGIES (to medication/drugs):

	Yes	No		Yes	No
Penicillin	<input type="checkbox"/>	<input type="checkbox"/>	Codeine	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa Drugs	<input type="checkbox"/>	<input type="checkbox"/>	Iodine/Betadine	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	Novocain	<input type="checkbox"/>	<input type="checkbox"/>
Motrin (Ibuprofen)	<input type="checkbox"/>	<input type="checkbox"/>	Tapes/Adhesives	<input type="checkbox"/>	<input type="checkbox"/>
Other Anesthesia If yes, please list: _____	<input type="checkbox"/>	<input type="checkbox"/>	Food Allergies If yes, please list: _____	<input type="checkbox"/>	<input type="checkbox"/>

MEDICINES (List all medications you are now taking):
