Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Artificial joints
Asthma
Atrial fibrillation
BPH
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Valve Replacement
None

Other

_____

_____

_____

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy: *(Right, Left, Both)*
Lumpectomy: *(Right, Left, Both)*
Breast Biopsy: *(Right, Left, Both)*
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
PTCA
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement within last 2 years
Kidney Biopsy
Kidney Removed: *(Right, Left)*
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP
Skin Biopsy
Basal Cell Cancer Surgery
Squamous Cell Carcinoma Surgery
Melanoma Surgery
Spleen Removed
Testicles Removed *(Right, Left, Both)*
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
None

Other

_____

_____

_____

Orthopedic History: (please circle all that apply)

Ankylosing Spondylitis
Bursitis
DISH
Distal Radius Fracture
Epidural Injections, Spine
Fracture
Gout
Hip Fracture
HNP, Cervical
HNP, Lumbar
Metastatic Bone Disease
Osteoarthritis
Osteopenia
Osteoporosis
Primary Bone Sarcoma
Psoriatic Arthritis
Ricketts
RSD
Sciatic
Scolisis
Soft Tissue Sarcoma
Spinal Stenosis, Cervical
Spinal Stenosis, Lumbar
Vertebral Body Compression Fracture
Vitamin D Deficiency
None

Other

_____

_____

_____

Orthopoedic Surgery: (please circle all that apply)

Ankle Fracture: *(Right, Left, Both)*
Carpal Tunnel Decompression: *(Right, Left, Both)*
Cervical Spine Surgery: ACDF
Cervical Spine Surgery: Disc Replacement
Distal Radius ORIF: *(Right, Left, Both)*
Intermedullary Nailing Femur *(Right, Left, Both)*
Intermedullary Nailing Tibia: *(Right, Left, Both)*
Joint Replacement: Hip *(Right, Left, Both)*
Joint Replacement: Knee *(Right, Left, Both)*
Joint Replacement: Shoulder *(Right, Left, Both)*
Knee Arthroscopy: *(Right, Left, Both)*
Kyphoplasty/Vertebroplasty
Lumbar Spine Surgery: Decompression
Lumbar Spine Surgery: Decompression and Fusion
Lumbar Spine Surgery: Disc Replacement
Rotator Cuff Repair: *(Right, Left, Both)*
None

Other

_____
_____
_____

Family History: (please circle all that apply)

Condition	Which family member?
Charcot Marie Tooth Disease	_____
Diabetes	_____
Hypertension	_____
Multiple Hereditary Exostosis	_____
Osteoarthritis	_____
Osteoporosis	_____
Scoliosis	_____
Other _____	_____

Medications: (Please list all current medications)

_____
_____
_____
_____
_____
_____
_____
_____

None

Allergies: (Please enter all allergies)

Drug_____Reaction(hives,vomiting,rash, etc)____

_____
_____
_____
_____
_____
_____

No Drug Allergies (circle if this applies to you)

What Pharmacy do you use? Name _____

Address _____

Phone _____

Social History: (Please circle all that apply)

Cigarette Smoking:

- Never smoked
- Quit: former smoker
- Smokes less than daily
- Smokes daily

Alcohol Use:

- Alcohol: none
- Alcohol: less than 1 drink a day
- Alcohol: 1-2 drinks a day
- Alcohol: 3 or more drinks a day

How often do you exercise?

- Several times a day
- Once a day
- A few times a week
- A few times a month
- Never
- Other

Occupation: _____

Are you right or left handed? (Circle one) Right handed Left Handed

Are you currently living in a nursing home or assisted living facility? _____Yes _____No