# NORTH SHORE ORTHOPAEDICS, S.C.

## PATIENT HISTORY

LAST NAME ______________________ FIRST NAME ______________________ MIDDLE __________

PRIMARY CARE PHYSICIAN __________________________ REFERRED BY ______________________

HEIGHT __________ WEIGHT __________ AGE __________

**LIST ANY PREVIOUS SURGERIES BY OTHER PHYSICIANS**

| DATE | SURGICAL PROCEDURE | PHYSICIAN | HOSPITAL |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**MEDICATIONS**

LIST ALL YOUR MEDICATIONS BELOW. PLEASE INCLUDE VITAMIN OR HERBAL SUPPLEMENTS
IF YOUR MEDICATION LIST IS LONG, PLEASE ASK FOR ASSISTANCE

| MEDICATION & DOSAGE | REASON | MEDICATION & DOSAGE | REASON |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**DO YOU HAVE ALLERGIES TO ANY MEDICATIONS?**

| | YES | NO | | YES | NO | | YES | NO | | YES | NO |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ANTI-INFLAMMATORIES | | | PENICILLIN | | | CODEINE | | | DARVON | | |
| TETRACYCLINES | | | LATEX | | | ASPIRIN | | | SULFA | | |

OTHER ________________________________________ NONE THAT ARE KNOWN ________

**DO YOU NOW OR HAVE HAD ANY PROBLEMS RELATED TO THE FOLLOWING DISEASES OR SYMPTOMS?**

| | YES | NO | | YES | NO | | YES | NO |
|---|---|---|---|---|---|---|---|---|
| HIGH BLOOD PRESSURE | | | CANCER | | | ABDOMINAL PAIN | | |
| CORONARY HEART DISEASE | | | *IF YES, TYPE* | | | BOWEL / BLADDER | | |
| BLOOD CLOTS | | | ULCERS | | | JOINT PAIN | | |
| BLEEDING TENDENCY | | | GOUT | | | EXCESSIVE THIRST | | |
| TB (TUBERCULOSIS) | | | DEPRESSION | | | OVER ALL FATIGUE | | |
| VENEREAL DISEASE | | | ANEMIA | | | BREATHING DIFFICULTY | | |
| ARTHRITIS | | | HEPATITIS (A/B/C) | | | CHEST PAIN | | |
| RHEUMATOID ARTHRITIS | | | SICKLE CELL | | | WEIGHT LOSS / GAIN | | |
| DIABETES | | | HIV+ / AIDS | | | VISION PROBLEMS | | |
| INSULIN DEPENDENT | | | EMPHYSEMA | | | HEADACHES | | |
| SUBSTANCE ABUSE | | | THYROID DISEASE | | | SKIN CONDITIONS | | |
| | | | | | | TINGLING / NUMBNESS | | |

DO YOU USE TOBACCO PRODUCTS? ______NO _____ YES _____ PACKS PER DAY

DO YOU CONSUME ALCOHOL? _____ NEVER _____ OCCASIONALLY _____ DAILY

**CHECK ANY OF THE FOLLOWING ILLNESSES IN YOUR IMMEDIATE FAMILY:**

INDICATE WHICH FAMILY MEMBER NEXT TO THE ILLNESS M=MOTHER F=FATHER S=SIBLING C=CHILD

| | | | | | |
|---|---|---|---|---|---|
| DIABETES MELLITUS | | HEART DISEASE | | HYPERTENSION | |
| LIVER DISEASE | | KIDNEY DISEASE | | NEUROLOGICAL PROBLEMS | |
| ARTHRITIS | | CANCER | | NONE THAT IS KNOWN | |

**WHO MAY WE CONTACT IN CASE OF AN EMERGENCY?**

NAME ______________________ PHONE __________________ RELATIONSHIP ____________

**PATIENT'S SIGNATURE** ________________________________ DATE ____________

PHYSICIAN'S INITIALS __________ DATE ____________