Eastern Oregon Orthopaedic Surgery & Fracture Clinic, Inc.

Medical History: **Name:** _____ **Age:** _____ **DOB:** _____

Please list all medications (prescription, vitamins, herbal, etc.): **Family Doctor:** _____

_____

_____ **Pharmacy:** _____

_____ _____

Please list all allergies to any medications, latex, tapes, etc.:

_____ ☐ Check here if no known allergies.

_____ ☐ Are you claustrophobic?

Please list any orthopedic conditions and approximate year:

_____

Please list all surgeries you have had and the approximate year:

_____

_____

Please circle "Y" or "N" in each box as they apply to the patient. Please mark an "X" in the box following if the condition applies to any family members (mother, father, siblings, children, grandparents).

			FAMILY				FAMILY
Asthma	Y	N		Thyroid Disorder	Y	N	
Hearing Problems	Y	N		Anemia	Y	N	
Diabetes	Y	N		Stroke	Y	N	
Tuberculosis	Y	N		Multiple Sclerosis	Y	N	
High Blood Pressure	Y	N		Blood Transfusion	Y	N	
Scoliosis	Y	N		Heart Attack/Problems	Y	N	
Kidney Disorder	Y	N		Blood Clots	Y	N	
Meningitis	Y	N		Heart Catheterizations	Y	N	
Polio	Y	N		Weakness or Paralysis	Y	N	
Head Injury	Y	N		Ulcers	Y	N	
Rheumatic Fever	Y	N		Epilepsy/Seizures	Y	N	
Hiatal Hernia	Y	N		Liver Disease	Y	N	
Arthritis	Y	N		Jaundice	Y	N	
Cancer	Y	N		Hepatitis	Y	N	
Bladder/Prostate Problems	Y	N		Emphysema/Pneumonia	Y	N	
Gallbladder	Y	N		Problems with Anesthesia	Y	N	
Excess Bleeding from Surgery	Y	N		Have you been tested for HIV/AIDS?	Y	N	
Frequent Headaches/Migraines	Y	N		Have you tested positive for MRSA?	Y	N	
Pacemaker:	Y	N		Other:	Y	N	

Social History:

What type of work do you do? _____

Are you currently working? YES NO If no, when was your last day worked? _____

Do you smoke? YES NO How much? _____ per day How long have you smoked? _____

Have you quit smoking? YES NO When? _____

Do you drink alcohol? YES NO How much? _____ per day/week/month.

Is there any chance you could be pregnant? YES NO Date of last menstrual period _____

The above information is completed to the best of my knowledge.

I have reviewed the above information.

_____ _____

Patient Signature Date Physician's Signature Date