ST. HELENA
Sports Medicine
& ORTHOPAEDICS

Medical History Form

Patient Name: _____Date:_____

Date of Birth: _____ Family Physician: _____

Complaint: _____
Date of injury: _____
Have you been treated for this problem prior to coming to the office? **YES / NO**
Where? _____When ? _____
Is your injury or complaint work related? **YES / NO**
Are you currently on disability? **YES / NO**
Are you currently working? **YES / NO**
Describe the work you currently do_____
Social History: **MARRIED / SINGLE / WIDOW**

Do you use alcohol? **YES / NO** Do you smoke? **YES / NO** Use Drugs? **YES / NO**

Past Medical History: What previous medical problems have you been treated for?

- ☐ Alcoholism
- ☐ Asthma
- ☐ Drug addiction
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Insulin Dependent Diabetes
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Non-Insulin Dependent Diabetes
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Thyroid Disease

Cancer: **YES / NO** If so what type: _____

Past surgical history: What previous surgeries have you had? When? _____
_____
What previous Orthopaedic surgeries have you had? When? _____
_____
Did you have any complications with the surgery or anesthesia? **YES / NO**
Do you have any bleeding disorders? **YES / NO** Do you take any blood thinners? **YES / NO**
Do you currently have complaints with any of the following?

- ☐ Bowel Complaints
- ☐ Chest Pain
- ☐ Chills
- ☐ Diarrhea
- ☐ Difficulty Breathing
- ☐ Dizziness
- ☐ Eyes Ears Nose
- ☐ Fevers
- ☐ Headaches
- ☐ High Blood Pressure
- ☐ Muscle weakness
- ☐ Shortness of Breath
- ☐ Skin Lesions
- ☐ Throat complaints
- ☐ Ulcers
- ☐ Urinary Tract Infections
- ☐ Weight Gain
- ☐ Weight Loss

Do you have any other medical conditions or problems that have not been discussed?
_____

_____ OR _____
Signature of Patient Parent / Legal Guardian / Authorized Person

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Medications

List Preferred Pharmacy: _____

Are you allergic to any medications? **Yes / No**

If Yes Please List: _____

List Current Medications:

_____

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Finished