CHARLOTTE ORTHOPAEDIC CLINIC

Patient Medical History Update

Today's date: ____________________

Patient Name: ________________________________ D.O.B.: _____/______/_______
Address: ____
What brings you in today? ____

Do you have any medical conditions (treated or untreated)?

Condition			Condition		
AIDS	☐ yes	☐ no	Anemia	☐ yes	☐ no
Angina	☐ yes	☐ no	Asthma	☐ yes	☐ no
Emphysema/COPD	☐ yes	☐ no	Bladder/Kidney	☐ yes	☐ no
Bleeding disorder	☐ yes	☐ no	Blood clots	☐ yes	☐ no
Cancer Type:______________	☐ yes	☐ no	Diabetes	☐ yes	☐ no
Anxiety	☐ yes	☐ no	Type:___________		
Depression	☐ yes	☐ no	Mental disorder	☐ yes	☐ no
Heart Attack	☐ yes	☐ no	Heart disease	☐ yes	☐ no
Atrial fibrillation	☐ yes	☐ no	High Blood Pressure	☐ yes	☐ no
Pacemaker	☐ yes	☐ no	Parkinson's	☐ yes	☐ no
Alzheimer's	☐ yes	☐ no	Gastric Ulcer	☐ yes	☐ no
Phlebitis	☐ yes	☐ no	Prostate disease	☐ yes	☐ no
Pulmonary emboli	☐ yes	☐ no	Stroke	☐ yes	☐ no
Thyroid disease	☐ yes	☐ no	Liver disease	☐ yes	☐ no
Sleep apnea (on CPAP)	☐ yes	☐ no	Peripheral neuropathy	☐ yes	☐ no
Glaucoma	☐ yes	☐ no	Macular degeneration	☐ yes	☐ no

Other illnesses not listed: ____

____

SURGICAL HISTORY

Surgery			Surgery		
Tonsillectomy	☐ yes	☐ no	Appendectomy	☐ yes	☐ no
Hysterectomy	☐ yes	☐ no	Prostate	☐ yes	☐ no
Cardiac Stent	☐ yes	☐ no	Cardiac Bypass	☐ yes	☐ no
Vascular surgery	☐ yes	☐ no	Laparoscopy	☐ yes	☐ no
Shoulder/Rotator cuff	☐ yes	☐ no	Knee arthroscopy	☐ yes	☐ no

Other surgery not listed: ____

____

____

Family History

☐ Unknown (adopted, etc.)

	Alive & well	Alive & Significant Medical Condition. (please list)	Deceased (please list cause)
Mother			
Father			
Siblings			
Children			

Please Turn form over (2 sided)

Allergies:

□ NONE □ Penicillin □ Sulfa □ Codeine □ Latex □ Aspirin Other: _______________

Medications:

If you have a list of your medications, please bring to the receptionist upon completion of this form so that we may photocopy it.

Medication	Frequency	Medication	Frequency

Social History:

Height:__________ Weight:____________

Please circle: White (Caucasian) Black/African American Hispanic Native American Asian Other/Prefer not to answer

Please circle: Married Widowed Single Divorced Other: ___________________________

Please circle: Employed Unemployed Retired Student Other: ___________________________

Tobacco Use: □ Never □ Past □ Current Packs Per Day: ____________ How Many Years: __________

Alcohol Use: □ None □ Current Drinks Per Week: _____________ Type: ____________________

Illicit drug use: □ Never □ Past □ Current

Current Primary Care Dr.: _____________________________Phone: ____________________

Current Local Pharmacy: ______________________________Phone: ____________________