MEDICAL HISTORY **Name**: ______________________________________

Referring Physician: ________________ **Date**: ___/___/___

Reason for consulting an Orthopaedic Surgeon: _______________________________________

Is **this the result of an injury?** ÿ **Yes** ÿ **No** **Date of onset:** ___/___/___

If yes, how did it happen? ____

If yes, where did it happen? ____

List any tests or x-rays you have had for this problem: _________________________________

____

Write in any operations or major illness requiring hospitalization.

Hospital	Year	Reason

Have you ever had: **If yes, please explain briefly**

ÿ **Asthma** ____

ÿ **Bleeding disorder** ____

ÿ **Blood Clots – Emolus** ____

ÿ **Diabetes** ____

ÿ **Heart attack** ____

ÿ **Heart failure** ____

ÿ **Heart murmur** ____

ÿ **High blood pressure** ____

ÿ **Jaundice** ____

ÿ **Pneumonia** ____

ÿ **Severe Kidney problems** ____

ÿ **Tuberculosis** ____

ÿ **Ulcer or bleeding from the stomach or colon** ____

Name any medication you are presently taking ____

Name any drugs to witch you are allergic ____

Are you a: **Nonsmoker** _____ **Smoker** _____

Height _____ **Weigh**t _____