Mountain View Orthopaedics
mtviewortho.com

Medical History

Today's Date (MM / DD / YYYY) / /

Name Height ft inches Weight pounds

Drug Allergies (If none, please indicate so. Attach an additional sheet if needed.)

Drug name Reaction

Drug name Reaction

Latex Allergy Yes No Reaction

Poultry Allergy Yes No Reaction

Tape Allergy Yes No Reaction

Complications with anesthesia Yes No Complication

Medication List (Please include all prescribed and over the counter vitamins/medications. If none, please indicate so.)

Medication Dosage Frequency Reason

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Attach an additional sheet if needed for all medications to be listed.

*** Are you under a narcotic agreement with another physician? Yes No

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Surgical History (Please identify all past surgeries. If none, please indicate so.)

Tonsils Appendix Gallbladder Hernia: umbilical inguinal hiatal

Bladder Kidney Lap band Gastric Bypass

Males: Vasectomy Prostate

Females: C-Section Tubal ligation Mastectomy: R L Both

D&C Hysterectomy: Complete Partial

Cardiac Procedure: Stent Catheterization Bypass Pacemaker

Other Procedures

Past Orthopaedic Surgeries (If none, please indicate so.)

Surgery Date of Surgery (MM / YYYY) / Surgeon

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Medical Conditions (Please indicate all that apply.)

Lung Asthma Shortness of Breath Pneumonia COPD Bronchitis Other

Blood Disorders Anemia Transfusions Clotting/Bleeding disorder Other

Digestive Disorder Ulcer Acid reflux Other

Kidney/Bladder Disorder Infection Kidney Stones Incontinence Other

Metabolic Disorders Gout Jaundice Hepatitis Thyroid Disorder? hypo hyper

Diabetes No Yes Insulin dependent Non-insulin dependent Other

Eyes/Ears/Nose/Throat Eyeglasses Contacts Hearing loss Sinusitis Seasonal allergies

Neuromuscular Convulsions Seizures Stroke Paralysis Anxiety

Depression Bipolar disorder Fibromyalgia Other

Heart Disorder A-fib Heart murmur Heart attack Angina Palpitations Cardiac Surgery

High blood pressure High Cholesterol MitralValve Prolapse Arrhythmia

Bone/Joint Disease Arthritis Rheumatoid arthritis Congenital deformity Other

History of Cancer No Yes When Treatment

Have you ever had a pulmonary embolism (PE) or Blood Clot (DVT)? No Yes Where

Are you disabled? No Yes Nature of disability

Other medical conditions not listed above

Family Medical History:

Mother Heart disease Stroke Diabetes Other In good health Deceased

Father Heart disease Stroke Diabetes Other In good health Deceased

Personal Habits

Alcohol Use No Yes How much?

Recreational Drugs No Yes Please specify

Tobacco Use Never used Yes Please specify how much daily Year started smoking

Former smoker? Yes Please specify # of years smoked Year quit smoking

Smokeless No Yes Please specify how much daily Year started

At risk for second hand smoke No Yes