Medical History

Mountain View Orthopaedics

mtviewortho.com

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 _____

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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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Medication _____ Dosage _____ Frequency _____ Reason _____

Medication _____ Dosage _____ Frequency _____ Reason _____

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

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

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