ORTHOPAEDIC CLINIC OF DAYTONA BEACH, P.A. Date: ___/___/_____
MEDICAL HISTORY FORM m / d / year

Patient Name:_____ Date of Birth: ___/___/_____ Age:____ ❒ Male ❒ Female
m / d / year

PHYSICIANS:
Primary Care: _____
Cardiologist: _____
Neurologist: _____
Other: _____

MEDICAL HISTORY:

	YES	NO	Explain
Asthma / COPD	❒	❒	_____
Kidney/Bladder/Prostate	❒	❒	_____
Heart Disease / Heart Attack	❒	❒	_____
High Blood Pressure	❒	❒	_____
Stroke	❒	❒	_____
High Cholesterol	❒	❒	_____
Diabetes	❒	❒	_____
Gastric Reflux / Ulcer	❒	❒	_____
Cancer	❒	❒	_____
Liver/Gallbladder	❒	❒	_____
Thyroid Disease	❒	❒	_____
Serious Infections	❒	❒	_____
Osteoporosis	❒	❒	_____
Blood Clots	❒	❒	_____
Prior Anesthesia Problems	❒	❒	_____
Scoliosis	❒	❒	_____
Other Conditions:	❒	❒	_____

_____

SURGICAL HISTORY:

Operations performed	**Year**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Previous fractures (broken bones)

_____	_____
_____	_____
_____	_____
_____	_____

Other previous injuries or hospitalizations

_____	_____
_____	_____

ALLERGIES:

Drug	Type of Reaction
_____	
_____	

CURRENT MEDICATIONS:
Name (and dose) : _____
Name (and dose) : _____
Name (and dose) : _____
Name (and dose) : _____
Name (and dose) : _____
Name (and dose) : _____
Name (and dose) : _____
Name (and dose) : _____
Name (and dose) : _____

VITAMINS / HERBAL MEDICINES / SUPPLEMENTS:
Name (and dose) : _____
Name (and dose) : _____
Name (and dose) : _____
Name (and dose) : _____

SOCIAL HISTORY:
Employer:_____
Occupation:_____ Retired: ❒Yes ❒No
Disabled: ❒Yes ❒No If so why? _____

Marital Status: ❒Single ❒Married ❒Divorced ❒Widow
Who do you live with?_____

Immunizations Current? (Ages up to 15) ❒Yes ❒No

Previous Smoker: ❒Yes ❒No # of Yrs.___Packs/day :____
Current Smoker: ❒Yes ❒No # of Yrs.___Packs/day:____

Previous Alcohol Use: ❒Yes ❒No Amt:_____ per day
Current Alcohol Use: ❒Yes ❒No Amt:_____ per day

FAMILY HISTORY:
(Medical conditions your blood relatives have had)

	YES	NO	Relative
Heart Disease	❒	❒	_____
Cancer	❒	❒	_____
Diabetes	❒	❒	_____
Stroke	❒	❒	_____
Kidney Disease	❒	❒	_____
Bleeding Tendency	❒	❒	_____
Asthma	❒	❒	_____
Anesthetic Reaction	❒	❒	_____

Other serious medical conditions in your family

Condition/Disease	Relative
_____	_____
_____	_____

REVIEW OF SYSTEMS:

	YES	NO	Explain:
Recent Fever / Chills	❒	❒	_____
Irregular Heart Beat	❒	❒	_____
Angina / Chest Pain	❒	❒	_____
Shortness of breath	❒	❒	_____
Nausea or Vomiting	❒	❒	_____
Urination Changes	❒	❒	_____
Skin Rash	❒	❒	_____
Bleeding Tendencies	❒	❒	_____
Joint Swelling	❒	❒	_____
Depression or Anxiety	❒	❒	_____
Weakness	❒	❒	_____
Numbness	❒	❒	_____
Varicose Veins	❒	❒	_____

Other:_____