

WEST BAY ORTHOPAEDIC ASSOCIATES, INC.

Patient Name: _____ DOB _____ Today's Date _____

PAST MEDICAL HISTORY

The name of your **PRIMARY CARE PHYSICIAN** is: _____

Other than your Primary Care Physician, are you under the care **OF ANOTHER PHYSICIAN?**
If yes, please list

Please list all **MEDICATIONS** you are currently taking (Birth Control Pills are included in this category):

Please list any **BLOOD THINNERS** (Coumadin, Aspirin, Others) that you are currently taking:

Please list any and all **ALLERGIES** to Penicillin or any other drugs:

Have you had **ABNORMAL BLEEDING** associated with previous surgery or trauma? _____

FAMILY HISTORY

Please list any significant **FAMILY MEDICAL CONDITIONS**: _____

SOCIAL HISTORY

OCCUPATION: _____

WORK STATUS (Please circle one): Full Duty Light Duty Not Working

Do you **SMOKE**? _____ If yes, **HOW MUCH/OFTEN**: _____

Do you use **ALCOHOL**? _____ If yes, **HOW MUCH/OFTEN**: _____

Do you have a **HISTORY OF DRUG AND/OR ALCOHOL DEPENDANCY**? _____

SURGICAL & FRACTURE HISTORY

Please list **ALL SURGERIES** you have had **AND WHO PERFORMED THE SURGERY:**

Please list all **FRACTURES** that you have had:

MEDICAL CONDITIONS / PAST & PRESENT

Place an (X) next to **PREVIOUS AND/OR CURRENT CONDITIONS:**

Hepatitis	_____	Phlebitis (Blood Clots)	_____
Jaundice	_____	Heart Attack or Coronary	_____
Aids or Aids Virus	_____	Angina	_____
Rheumatic Fever	_____	Heart Surgery	_____
Heart Murmur	_____	Cardiac Pacemaker	_____
Valve/Heart Wall Defect	_____	Stroke	_____
Sugar Diabetes	_____	Benign Tumor or Cancer	_____
High Blood Pressure	_____	Radiation Therapy	_____
Low Blood Pressure	_____	Epilepsy or Seizure Disorder	_____
Kidney Problems	_____	Bone, Joint or Muscle Problems	_____
Herpes Simplex I,II	_____	Asthma	_____
Tuberculosis (Positive Test)	_____	Stomach or Duodenal Ulcers	_____
Relative w/ Tuberculosis	_____	Hearing Disorder	_____
Blood Refused for Donation	_____	Alcohol Dependency	_____
Blood Transfusion	_____	Tobacco Dependency	_____
Hemophilia/Bleeding Disorder	_____	Drug Dependency	_____
Anemia	_____	Lung Problems	_____
OTHER (Please list):		Are you Pregnant/Nursing	_____
_____		Gonorrhea or Syphilis	_____
_____		Other Venereal Diseases	_____
_____		Thyroid Disorder	_____

REVIEW OF SYMPTOMS (Continued)Place an (X) next to **SYMPTOMS YOU HAVE NOW:**

Fever, Chills	_____	Abdominal Pain	_____
Excess Sweating	_____	Nausea/Vomiting	_____
Fatigue	_____	Black Stools	_____
Trouble w/ Vision	_____	Rectal Bleeding	_____
Eye Pain/Redness	_____	Vomiting Blood	_____
Hearing Trouble	_____	Depression	_____
Nose Bleeds	_____	Weight Loss	_____
Throat Discomfort	_____	Diarrhea	_____
Cough	_____	Arthritis	_____
Sputum	_____	Nighttime Urination	_____
Wheezing	_____	Bruise/Bleed Easily	_____
Chest Pains	_____	Hot Weather Intolerance	_____
Nervousness	_____	Cold Weather Intolerance	_____
Palpitations	_____	Increased Thirst	_____
Shortness of Breath	_____	Increased Urine Volume	_____
Swollen Feet/Ankles	_____	Fainting	_____
High Blood Pressure	_____	Numbness/Tingling	_____
Jaundice	_____	Tremors	_____
Heartburn	_____	Muscle Weakness	_____
Difficulty Swallowing	_____	Paralysis	_____

Patient Signature: _____

Date: _____

Physician Signature: _____

Date: _____

West Bay Orthopaedic Associates, Inc.