Pontchartrain Bone & Joint Clinic
Medical History Questionnaire

(Please Print)

Past Medical History (please check all that apply)

	Illness/Injury		Illness/Injury
	High blood pressure		Asthma
	Diabetes		Lung disease (please specify_____)
	Heart attack		Kidney disease (please specify_____)
	Heart problems (please specify_____)		Liver disease (please specify_____)
	Ulcers, stomach or intestinal		Previous anesthesia problems
	Stroke (when_____)		Thyroid problems
	Cancer (please specify_____)		Blood clots/DVT's
	Hepatitis		Bleeding tendency
	HIV/AIDS		Osteoporosis
	Arthritis		Females: Are you or could you be pregnant
	Rheumatologic disease		
	Gout		Other: _____

Past Surgical History (please list previous surgeries)

	Date	Type of Operation	Complication/problems
1			
2			
3			
4			
5			
6			
7			
8			

Please list any current medications

Drug	Dosage and frequency	Drug	Dosage and frequency
1)		6)	
2)		7)	
3)		8)	
4)		9)	
5)		10)	

Do you take blood thinners? □ yes □ no

Do you have any drug allergies? □ yes □ no

If yes, please list.

Drug	Reaction	Drug	Reaction
1)		5)	
2)		6)	
3)		7)	
4)		8)	

Please list any other allergies (e.g. egg, iodine, latex). _____

Doctor's Notes:

Social History

Do you use tobacco?	□ no	□ yes, # of packs/day ____ # of years ____
Did you use tobacco?	□ no	□ yes, when did you quit? _____
Do you drink alcoholic beverages?	□ no	□ yes, what type and how often _____
Are you: □ single □ married □ divorced □ widowed		

Family History **(please list any family problems that apply)**

	Illness/Injury		Illness/Injury
	Heart Disease		Rheumatoid arthritis
	Diabetes		Gout
	High blood pressure		Degenerative arthritis
	Cancer (please specify_____)		Immunologic disorder
	Anesthesia problems		Other: _____

Review Of Systems **(please check any recent problems)**

	Constitutional symptoms		**Gastrointestinal**		**Neurological**
	Recent weight change		Loss of appetite		Frequent Headaches
	Fever		Nausea or vomiting		Light headed or dizzy
	Unexplained sweating		Frequent diarrhea		Seizures
	Eyes		Constipation		Numbness or tingling
	Wear glasses or contacts		Blood in stool or rectal bleeding		Tremors
	Blurry or double vision		Black tarry stools		Paralysis
	Glaucoma		Abdominal pain or heartburn		**Psychiatric**
	Ear ,Nose, Throat		**Genitourinary**		Memory loss or confusion
	Hearing Loss		Frequent urination		Anxiety
	Regular nose or gum bleeding		Burning or painful urination		Insomnia
	Sore throat		Blood in urine		Depression
	Swollen glands in the neck		Incontinence or dribbling		**Endocrine**
	Cardiovascular		Female: ____ # of pregnancies		Glandular or hormone problem
	Irregular heart beats		Female: ____# of miscarriages		Excessive thirst or urination
	Shortness of breath		**Musculoskeletal**		Heat or cold intolerance
	Chest pain		Joint pain		Changes in hair or nails
	Swelling in the feet, ankles, or hands		Joint stiffness and swelling		**Hematology**
	Fainting spells		Morning stiffness		Bleeding or bruising tendency
	Respiratory		Difficulty walking		Anemia
	Chronic or frequent coughing		Muscle cramping		History of blood transfusion
	Spitting up blood		**Integumentary**		
	Emphysema		Rash or itching		Height_____
	Wheezing		Changes in skin color		Weight _____
			Varicose veins		

Patient Signature (or parent/guardian if patient is a minor) _____ Date _____

Doctor:

I certify that I have reviewed the information on this form.

Doctor Signature	Date	Doctor Signature	Date	Doctor Signature	Date