PATIENT MEDICAL HISTORY

OPA ortho™

Patient Name _____
last first middle initial

Date of Birth ____/____/____ Gender ☐ Male ☐ Female Age _____ Height _____ Weight _____

Occupation _____ Retired? ☐ No ☐ Yes

Primary Care Physician _____ Referred by: _____

Is this a work related injury? ☐ No ☐ Yes

PERSONAL MEDICAL HISTORY (Please check if YOU currently have or had the following diseases/conditions and circle any that apply.)

- ☐ Glaucoma
- ☐ Epilepsy/Seizures/Convulsions
- ☐ Stroke/TIA
- ☐ High Blood Pressure
- ☐ Heart Problems/Heart Attack/Irregular Heartbeat
- ☐ DVT/Pulmonary Embolism/Blood Clots
- ☐ Anemia/Bleeding Disorder
- ☐ Asthma/COPD/Emphysema/Breathing Problems
- ☐ Diabetes
- ☐ Thyroid Disorder
- ☐ Liver Diseases/Hepatitis (Type: _____)
- ☐ Kidney Disease/Kidney Stones
- ☐ Prostate Disease
- ☐ Arthritis
- ☐ Gout
- ☐ Osteoporosis/Osteopenia
- ☐ Cancer (Type: _____)
- ☐ Communicable Diseases
- ☐ Tuberculosis
- ☐ Antibiotic Resistant Infection/MRSA
- ☐ Allergy to Antibiotics (Reaction: _____)
- ☐ HIV
- ☐ Steroid Use
- ☐ Metal Allergy
- ☐ Anesthesia Difficulties/Malignant Hyperthermia
- ☐ Other (List: _____)
- ☐ None

PREVIOUS SURGERIES (Please list ALL previous surgeries and date.)

Procedure / Date	Procedure / Date
1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

MEDICATIONS (Please list ALL medications including prescriptions, over-the-counter medications and blood thinning medications such as Coumadin, Plavix, aspirin, etc.)

Procedure / Date	Dose	How Often
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

OVER →

PATIENT MEDICAL HISTORY

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ALLERGIES (Please list ALL allergies including contrast dyes, metal, latex, medication or other.)

Name	Specify Reaction (hives, rash, breathing difficulty, anaphylaxis)
1.	
2.	
3.	
4.	
5.	

MEDICAL FAMILY HISTORY (Please check if anyone in your FAMILY has or had the following diseases/conditions and circle the applicable condition.)

- ☐ Glaucoma
- ☐ Epilepsy/Seizures/Convulsions
- ☐ High Blood Pressure
- ☐ Heart Problems/Heart Attack/Irregular Heartbeat/Stroke
- ☐ DVT/Pulmonary Embolism/Blood Clots
- ☐ Anemia/Bleeding Disorder
- ☐ Asthma/Breathing Problems/Emphysema
- ☐ Diabetes
- ☐ Thyroid Disorder
- ☐ Liver Diseases/Hepatitis (Type: _____)
- ☐ Kidney Problems
- ☐ Arthritis
- ☐ Gout
- ☐ Osteoporosis/Osteopenia
- ☐ Cancer (Type: _____)
- ☐ Metal Allergy
- ☐ Other (List: _____)
- ☐ None

SOCIAL HISTORY

Do you use tobacco? ☐ No ☐ Yes Packs Per Day: _____ If Quit when: _____

Do you drink alcohol? ☐ No ☐ Yes How Much/Often: _____

Are you pregnant? ☐ No ☐ Yes ☐ Possibly

Current or history of drug use? ☐ No ☐ Yes Type: _____

How many children do you have? _____ Number living with you? _____

REVIEW OF SYSTEMS (Please check if YOU are experiencing any of the following symptoms and circle any that apply.)

- ☐ Fever/Weight Loss or Gain/Chills/Fatigue
- ☐ Sore Throat/Difficulty Swallowing/Nose Bleeds/Ear or Hearing Problems/Headache/Migraines
- ☐ Excessive Thirst or Appetite/Excessive Urination/Heat or Cold Intolerable
- ☐ Visual Difficulty/Redness/Watery Eyes
- ☐ Chest Pain/Palpitations/Fainting/Murmurs
- ☐ Cough/Sputum Production/Snoring/Short of Breath/Wheezing
- ☐ Blood in Stool/Loss of Bowel Control/Nausea/Vomiting/Ulcers
- ☐ Bladder/Urological Problems/Painful Urination/Prostate Problems
- ☐ Bleeding Problems/Easy Bruising
- ☐ Joint Swelling/Stiffness/Redness/Heat/Muscle Pain/Swelling
- ☐ Depression/Nervousness/Anxiety/Hallucinations
- ☐ Skin Disorders/Rash/Poor Healing/Redness

The above information is true and correct to the best of my knowledge.

Patient Signature _____ Date _____

M.D. Review _____ Date _____