



PERSONAL MEDICAL HISTORY

NORTHWEST OKLAHOMA ORTHOPAEDIC CLINIC

A complete medical record assures your surgeon is well informed about your medical conditions.

PATIENT INFORMATION

Name: _____ Birthdate: _____ Age: _____ Visit Date: _____

Primary care physician/provider: _____ Who referred you? _____

What is your dominant hand: Left Right Height _____ Weight (lbs) _____

Marital Status: Single Married Widowed Divorced Separated Gender: Male Female

The **first** best number to reach you () _____ - _____ Cell Home Work Other

The **second** best number to reach you () _____ - _____ Cell Home Work Other

Current Email address: _____

VISIT HISTORY *(More than one reason for visit must be approved by our office prior to your appointment for scheduling purposes)*

Reason for visit? _____

Is this work related? Yes No

How did the problem start or injury occur? _____

Date of Onset / Accident
Or how many days, weeks, months or years: _____

Describe the expectations of today's visit: _____

ALLERGIES

PENICILLIN allergy? Yes No If YES, age at last reaction _____ and type of reaction _____

KEFLEX or ANCEF allergy? Yes No If YES, type of reaction _____

LATEX allergy? Yes No If YES, are special precautions taken Yes No

METAL allergy? Yes No Include difficulties with wearing metal jewelry against skin

List medical allergies and the reactions with each *(Note if they are Mild, Moderate, or Severe)*:

MEDICATIONS

List the prescription medications taken on a regular basis with **their doses and frequency** and then list any over-the-counter and herbal medications. (If a list is attached, the doses and frequencies must be present on the list)

Check here if you have provided a list

On any blood thinners? Yes No (e.g. Aspirin/Plavix/Coumadin/NSAIDs/Xarelto/Pradaxa/Eliquis/Cayenne Pepper/Garlic/Other)

Name and city of preferred pharmacy: _____

PAST SURGICAL HISTORY

Turn Over Page (must sign and date next page)

PAST MEDICAL HISTORY

(check all that apply)

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Diabetic or Pre-Diabetic If so, Last HgA1c _____ | <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Fracture _____ | <input type="checkbox"/> Immunocompromised <input type="checkbox"/> Kidney/Renal Disease | <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Prostate Disease |
| <input type="checkbox"/> History of Blood Clot (DVT or PE) Treatment _____ | <input type="checkbox"/> Spinal Stenosis <input type="checkbox"/> GERD / Reflux | <input type="checkbox"/> Liver Disease _____ | <input type="checkbox"/> Cancer _____ |
| <input type="checkbox"/> Atrial Fibrillation <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Glaucoma <input type="checkbox"/> Gout | <input type="checkbox"/> Lung Disease (Asthma, COPD, other _____) | <input type="checkbox"/> Mental Illness _____ |
| <input type="checkbox"/> Heart Attack / MI <input type="checkbox"/> Pacemaker or Defibrillator | <input type="checkbox"/> Autoimmune Disorder (Lupus, Scleroderma, Rheumatoid, Psoriasis, etc.) | <input type="checkbox"/> Malignant Hyperthermia <input type="checkbox"/> Neurological Disease | <input type="checkbox"/> Sickle-Cell <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Vascular Disease <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Chronic Pain Syndrome <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Multiple Sclerosis, Parkinson's, Seizure Disorder or other. | <input type="checkbox"/> Substance Abuse/Addiction |
| <input type="checkbox"/> Stroke / TIA <input type="checkbox"/> Back or Neck Surgery | <input type="checkbox"/> Hepatitis - Type _____ | <input type="checkbox"/> Muscle Disease _____ | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Neuropathy <input type="checkbox"/> Organ Transplant _____ | <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Other: _____ |

NONE OF THE ABOVE APPLY

For **female** patients - has there been Hysterectomy Bilateral tubal ligation Postmenopausal
Are there any **metal implants** in your body? Yes No If so, where: _____

FAMILY HISTORY

Heart disease Diabetes Stroke / CVA Cancer _____ Reaction to anesthesia Other
List any other family health information or illness that run in your biological family: _____

SOCIAL HISTORY

Smoke or use tobacco? Never Occasionally Daily Quit; When _____ Type _____
Use of E-cigarettes? Never Occasionally Daily Quit; When _____
Drink alcohol? Never Moderate / Socially Daily
Recreational or illicit drugs? Never Occasionally Daily Quit; When _____

Living Status Independent Alone Nursing home Assisted Living Other _____
Assistive Devices None Crutches Cane Walker Wheelchair Prosthesis
Functional Status - Can you? Drive Shop Cook Manage your own finances

If you have a **Medical Power of Attorney**, put their name here: _____

REVIEW OF SYSTEMS

| | |
|------------------|--|
| General | <input type="checkbox"/> Unplanned weight loss <input type="checkbox"/> Fever <input type="checkbox"/> Fatigue <input type="checkbox"/> Chills <input type="checkbox"/> Nausea |
| Eyes | <input type="checkbox"/> Pain <input type="checkbox"/> Poor vision <input type="checkbox"/> Corrective lenses |
| Ear/Nose/Throat | <input type="checkbox"/> Sore throat <input type="checkbox"/> Hoarseness <input type="checkbox"/> Ears ringing <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Vertigo |
| Respiratory | <input type="checkbox"/> Wheezing <input type="checkbox"/> Coughing <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Sleep apnea |
| Cardiovascular | <input type="checkbox"/> Chest pain <input type="checkbox"/> Fainting <input type="checkbox"/> Feet / legs swelling <input type="checkbox"/> Palpitations <input type="checkbox"/> Irregular heartbeat |
| Gastrointestinal | <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Bowel problems / changes |
| Urinary | <input type="checkbox"/> Pain / burning urination <input type="checkbox"/> Frequency <input type="checkbox"/> Flank pain <input type="checkbox"/> Voiding difficulty <input type="checkbox"/> Urgency |
| Musculoskeletal | <input type="checkbox"/> Joint swelling <input type="checkbox"/> Joint redness <input type="checkbox"/> Joint pain <input type="checkbox"/> Gait problems |
| Skin | <input type="checkbox"/> Rash <input type="checkbox"/> Itch <input type="checkbox"/> Sores <input type="checkbox"/> Abscess <input type="checkbox"/> Discharge |
| Endocrine | <input type="checkbox"/> Excess sweat <input type="checkbox"/> Excess thirst <input type="checkbox"/> Heat intolerance <input type="checkbox"/> Cold intolerance |
| Heme/Lymph | <input type="checkbox"/> Bleeding or clotting problems <input type="checkbox"/> Bruising easily <input type="checkbox"/> Lymph node swelling |
| Psych | <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Severe stress <input type="checkbox"/> Panic attacks <input type="checkbox"/> Claustrophobia |

SIGNATURE _____ **Date** _____ Rev. 22 Dec 2024