Thomas Health

Orthoclinic
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Past Medical and Surgical History

Medications (include over the counter meds)

_____
_____
_____

Allergies (Please list all)

_____
_____
_____

Past Medical History (check all that apply)

- ○ High Blood Pressure
- ○ High Cholesterol
- ○ Lung Disease
- ○ Kidney/Renal Disease
- ○ Bleeding Disorder
- ○ Heart Disease
- ○ Diabetes
- ○ Thyroid Disease
- ○ History of blood clots
- ○ History of MRSA
- ○ Other _____
- ○ Other _____

Past Surgical History (check all that apply)

- ○ Heart By-pass
- ○ Vascular Surgery
- ○ Hysterectomy
- ○ Knee Replacement
- ○ Hip Replacement
- ○ Rotator Cuff Repair
- ○ Carpal Tunnel
- ○ Arthroscopy
- ○ Spine Surgery
- ○ Other _____
- ○ Other _____

Cardiovascular (check all that apply)

- ○ Heart attack
- ○ Heart murmur
- ○ Chest pain or angina
- ○ Arrhythmia/irregular beats
- ○ Edema (swelling of feet or ankles)
- ○ Shortness of breath
- ○ Pacemaker/defibrillator
- ○ Palpitations
- ○ Aneurysm
- ○ Other _____
- ○ None of the above/negative

Respiratory (check all that apply)

- ○ Asthma or wheezing
- ○ Frequent or chronic cough
- ○ COPD (emphysema)
- ○ Tuberculosis
- ○ Coughing up blood
- ○ Coughing up phlegm
- ○ History of lung cancer
- ○ Other _____
- ○ None of the above/negative

Neurologic (check all that apply)

- ○ Stroke
- ○ Seizures
- ○ Numbness/tingling
- ○ Migraine headache
- ○ Paralysis
- ○ Dizziness
- ○ Speech difficulties
- ○ Other _____
- ○ None of the above/negative

Gastrointestinal (include over the counter meds)

- ○ Reflux
- ○ Hepatitis
- ○ Abdominal pain
- ○ Cancer
- ○ Ulcers
- ○ Colitis
- ○ Heartburn
- ○ Irritable bowel syndrome
- ○ Bloody stool
- ○ Other _____
- ○ None of the above/negative

Genitourinary (check all that apply)

- ○ Urinary tract infection
- ○ Prostate disease
- ○ Kidney stones
- ○ Urinary incontinence
- ○ Other _____
- ○ None of the above/negative

Musculoskeletal (include over the counter meds)

- ○ Rheumatoid disease
- ○ Fibromyalgia
- ○ Joint pain/stiffness/swelling
- ○ Arthritis
- ○ Lupus
- ○ Other _____
- ○ None of the above/negative

Do you smoke? Yes No # packs/day? _____
Do you drink alcohol? Yes No How much? _____