General Health History

DMOS ORTHOPAEDIC CENTERS

Date: _____

Name: _____ Date of Birth: _____ Sex: ☐ M ☐ F

Personal Physician: _____ Referring Physician: _____

Preferred Pharmacy & Location: _____

Past Medical History ☐ None

☐ Sleep Apnea
☐ High Blood Pressure
☐ Heart Disease
☐ Diabetes
☐ Asthma
☐ Pneumonia
☐ Emphysema
☐ Blood Clots
☐ Ulcer
☐ Anemia
☐ Seizures
☐ Liver Disease
☐ Hepatitis
☐ Gout
☐ Rheumatoid Arthritis
☐ Kidney Disease
☐ Stroke
☐ Cancer
☐ HIV
☐ Depression
☐ Anxiety

Other Illnesses _____

Orthopaedic Surgeries ☐ None

JOINT REPLACEMENT

R	L		YEAR
☐	☐	Shoulder	_____
☐	☐	Hip	_____
☐	☐	Knee	_____

JOINT SCOPE

R	L		YEAR
☐	☐	Shoulder	_____
☐	☐	Hip	_____
☐	☐	Knee	_____
☐	☐	Elbow	_____
☐	☐	Wrist	_____

ORTHOPAEDIC SURGERY

R	L		YEAR
☐	☐	Carpal Tunnel Release	_____
☐	☐	Trigger Finger Release	_____
☐	☐	Fracture Repair	_____
	☐	Neck Surgery	_____
	☐	Back Surgery	_____

Other Orthopaedic Surgeries _____

Surgeries ☐ None

☐ Appendectomy
☐ Tonsillectomy
☐ Gallbladder
☐ Hernia Repair
☐ Heart Surgery
☐ Heart Catheterization or Stent
☐ Coronary Artery Bypass
☐ Pacemaker
☐ Lower Extremity Bypass
☐ Cesarean Section
☐ Hysterectomy
☐ Prostate Surgery
☐ Surgical Wound Infections
☐ Anesthesia Complications

Other Surgeries _____

Prescription Medications ☐ None

DRUG NAME	DOSE	DRUG NAME	DOSE
1. _____	_____	6. _____	_____
2. _____	_____	7. _____	_____
3. _____	_____	8. _____	_____
4. _____	_____	9. _____	_____
5. _____	_____	10. _____	_____

Over-the-counter ☐ None

DRUG NAME	DOSE	DRUG NAME	DOSE
1. _____	_____	3. _____	_____
2. _____	_____	4. _____	_____

FLIP OVER PLEASE

Medical Allergies ☐ None

	REACTION	OTHER:	REACTION
☐ Penicillin		☐	
☐ Sulfa		☐	
☐ Latex		☐	

Social History

Do you live with someone who can assist you if needed? ☐ Yes ☐ No

Y	N		AMOUNT
☐	☐	Alcohol	_____ Drinks per day
☐	☐	Smoking	_____ Packs per day for ____ Years
☐	☐	Chewing Tobacco	_____ Years
☐	☐	Vaping or E-Cigarettes	_____ Years
☐	☐	Do you use recreational drugs?	_____ Years
☐	☐	Do you use marijuana?	_____ Years

Any other drug (besides marijuana) that we should know about? _____

Family History

Y	N		RELATION	Y	N		RELATION
☐	☐	Bleeding Disorders		☐	☐	Heart Disease	
☐	☐	Blood Clots		☐	☐	Anesthesia Complications	

Other: _____

Briefly describe your current orthopaedic problem and it's location, duration of symptoms, history of trauma, and previous treatments tried:

_____

_____

_____

_____

_____

_____

[DO NOT WRITE BELOW LINE - FOR OFFICE USE ONLY]

REVIEWED AND UPDATED **PHYSICIAN** _____ **DATE** _____