Precision Orthopaedics – Medical/Surgical History

Patient Name:	**Height:** **Weight:**
Medication Allergies: _____ _____	**Other Allergies: (Environmental, Seasonal, Food)** _____ _____
Social History: Tobacco: Yes No PPD: _____ Quit? _____ Alcohol: Yes No Frequency: _____ Caffeine: Yes No (Soda, Coffee, Tea, Chocolate) Recreational Drugs: Yes No	**Family History: (Cancer, Chronic Disease, Arthritis, Bone Problems)** _____ _____ _____ _____ _____ _____

Surgery/Hospitalization History: (Please list surgery/hospitalization/date below - or provide us with list to photocopy)

_____ _____

_____ _____

_____ _____

_____ _____

Chronic Problems: (Please check all that apply)

_____ Hypertension (high blood pressure) _____ Diabetes _____ Cardiac History

_____ Osteoporosis _____ COPD/Lung Disease

_____ Other (Please Describe) _____

Current Medications: *(Please list below – Name & Dosage – or provide us with a list to photocopy)*

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____
