ORTHOPAEDIC ASSOCIATES OF ZANESVILLE, INC

PAST MEDICAL HISTORY FORM

Name: ______________________________ **Date of Birth:** ____________________

Thank you for allowing us to participate in your orthopaedic care. Please complete the following information to assist us in gathering information about your health history.

PAST MEDICAL HISTORY (PATIENT): Please check all that apply ☑

Alcohol/Drug Abuse		Cushings Syndrome		Menopause	
Anemia		Diabetes		Menstruating Female	
Anesthesia Complications		Emphysema		Osteopenia	
Arthritis		HIV/AIDS		Osteoporosis	
Asthma		Heart Attack			
Atrial Fibrillation		Hepatitis		Sleep Apnea	
Bladder/Kidney Problems		High Blood Pressure		CPAP	
Blood Clot (leg)		High Cholesterol		BiPAP	
Blood Clot (lung)		Hyperparathyroidism		Stroke	
COPD		Infection		Transient Ischemic Attack (TIA)	
Cancer		Kidney Disease			
Coronary Artery Disease		Long term steroid use		No Current Problems	

OTHER: ____

FRACTURE/BROKEN BONE HISTORY (PATIENT)

Broken Bone	Right or Left?	When (year)?	Was Surgery Needed?	Comments
Shoulder				
Upper Arm/Elbow				
Lower Arm/Wrist				
Hand				
Finger (s)				
Thumb				
Hip/Upper Leg				
Knee				
Ankle/Lower Leg				
Foot				
Toe (s)				
Vertebral/spine				

OTHER: ____

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PAST MEDICAL HISTORY FORM

SURGICAL HISTORY (PATIENT): Please check all that apply ☑

Surgical Procedure	Yes	Year	Comments
No Previous Surgeries			
Abdominal Surgery			
Ankle/Foot Surgery			Circle: Right Left Both
Appendectomy (appendix removal)			
Back Surgery			
Bowel or Bladder Surgery			
Breast Surgery			Circle: Right Left Both
Cardiac Catheterization			
Carpal Tunnel Release			Circle: Right Left Both
Cataract Removal			Circle: Right Left Both
Colonoscopy			
Coronary (Heart) Bypass			
Coronary (Heart) Stent			
Defibrillator			
Endoscopy			
Gallbladder Removal			
Gastric Bypass Surgery			
Hand Surgery			Circle: Right Left Both
Heart Surgery			
Hernia Repair			
Hip Surgery			
Hysterectomy			Circle: Total Partial
Knee Surgery			Circle: Right Left Both
Lung Surgery			
Neck Surgery			
Ovary Removal			Circle: Right Left Both
Pacemaker			
Shoulder Surgery			Circle: Right Left Both
Tonsillectomy (tonsil removal)			
Vasectomy			
Wrist Surgery			Circle: Right Left Both

OTHER: ____

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PAST MEDICAL HISTORY FORM

FAMILY HISTORY (PATIENT'S FAMILY): Please check all that apply ☑

Medical Condition	Father	Mother	Son	Daughter	Brother	Sister
No Current Problems						
Alcoholism						
Anemia						
Anesthesia Complication						
Arthritis						
Asthma						
Bleeding Problem						
Blood Clot						
Cancer						
Coronary Artery Disease						
Diabetes						
Fracture/Broken Bone						
Heart Attack						
Hepatitis						
High Blood Pressure						
High Cholesterol						
HIV/AIDS						
Infection						
Kidney Disease						
Osteopenia						
Osteoporosis						
Stroke						
Transient Ischemic Attack						
Other:________________						
Other:________________						