SAH ORTHOPAEDIC ASSOCIATES
INSTITUTE FOR JOINT RESTORATION

Patient Medical History Form

Name:______________________________Date of Birth:_________Height______Weight______

Referred by (MD or colleagues):____

Past Medical History

Primary Care MD: Full Name:______________________________Date last visit:__________

Address:________________________________Ph #______________Fax # _______________

Pharmacy: Name/Address:___________________________________Ph #_______________

Please check any of the conditions listed below which you have had:

Asthma	High Blood Pressure	Stomach Ulcer/GERD
Emphysema/COPD	Heart Attack	Diabetes [ ] use insulin
Pulmonary Embolism	Pacemaker	Neurologic _______________
Venous Blood Clot Formation	Stroke	Depression
Sleep Apnea [ ] use CPAP	Arrhythmia	Mental Illness
Hepatitis/Cirrhosis	Kidney Disease	Seizure/Epilepsy
Thyroid Disease	BPH/urinary issues	Cancer _________________

Please list any other **Medical Conditions** for which you are currently under treatment (i.e. C*ardiologist, Nephrologist, Pulmonologist, Pain Specialist, Endocrinologist*, etc):

Condition	Treating Physician (Full Name)	Phone #	Date last seen

Please list every **Operation** you have had, including the year, surgeon and hospital if possible:

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Page Two – Patient Medical History Form

Please list all of your current medications:

Medication	Dosage (mg)	How often	Prescribed by

Allergies to medications and reaction:

____

____

Are you allergic to Latex? Yes No

Habits

Do you smoke? Yes No Pack per day______ Years smoking____
Have you ever smoked? Yes No Year you quit______ Years smoked____
Do you drink alcohol? Yes No Drinks per day < 2 3-4 5-6 ≥ 6

Family History

Do/did any of your brother, sisters or parents have any of the following:

Rheumatoid Arthritis______________________ Heart Attack______________________

Other Joint problems______________________ Cancer______________________

Bleeding problems______________________ Diabetes______________________

Anesthesia problems______________________ Stroke______________________

Mental Illness______________________ Thyroid Disease______________________

Social History

How many people live in your household (including you)?__________
How are they related to you?____
Do you have stairs at your home? Yes No Inside Outside