

<b>MEDICAL HISTORY (please check Yes or No for each item)</b>				
	<b>PATIENT</b>	<b>MANAGING PHYSICIAN</b>	<b>FAMILY</b>	<b>EXPLAIN (Who, Age)</b>
Diabetes	m Yes T No		m Yes T No	
If you have Diabetes, do you take: N Insulin <input type="checkbox"/> Oral agents <input type="checkbox"/> Diet controlled How long have you had diabetes?				
Osteoporosis	m Yes T No		m Yes T No	
Hypertension	m Yes T No		m Yes T No	
Cancer	m Yes T No		m Yes T No	
Stroke	m Yes T No		m Yes T No	
Paralysis	m Yes T No		m Yes T No	
Phlebitis/Deep Vein Thrombosis	m Yes T No		m Yes T No	
Miscarriage	m Yes T No		m Yes T No	
Heart Trouble	m Yes T No		m Yes T No	
Rheumatoid Arthritis	m Yes T No		m Yes T No	
Gout	m Yes T No		m Yes T No	
Convulsion/Seizure	m Yes T No		m Yes T No	
Lupus	m Yes T No		m Yes T No	
Ulcerative Colitis	m Yes T No		m Yes T No	
Crohn's Disease	m Yes T No		m Yes T No	
Scleroderma	m Yes T No		m Yes T No	

<b>PAST SURGICAL HISTORY</b>				
<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Brain	<input type="checkbox"/> Gallbladder	<input type="checkbox"/> Heart Bypass	<input type="checkbox"/> Hysterectomy
<input type="checkbox"/> Cataract L/R	m Hernia Repair L/R	m Kidney	m Oral	<input type="checkbox"/> Tonsils and Adenoids
m Stents	m Stomach	m Tubal Ligation	m Ortho Implants	Body Part:
<input type="checkbox"/> Orthopedic Surgery	Type: _____	Body Part: _____		
	Type: _____	Body Part: _____		
<input type="checkbox"/> Other	Type: _____			

<b>HOSPITALIZATION/SURGERY HISTORY (please list all hospitalizations and surgeries)</b>		
Name of Hospital	Purpose of Hospitalization	Date

<b>ALLERGIES (please list all known allergies and reactions)</b>		( Staff Only: Reviewed by
Allergen	Reaction	

<b>MEDICATION (please list all meds including over the counter medications and supplements)</b>		( Staff Only: Reviewed by
Medication/ Dosage	Medication/ Dosage	

Teays Valley Orthopedics

<b>Signature</b>	<b>Date</b>	<b>Relationship</b>
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