

SUMMIT ORTHOPAEDICS, LLP

Name: _____ Height: _____ Weight: _____ Age: _____ Today's Date: _____

SOCIAL HISTORY

Marital Status: Single Married Separated Divorced Widowed
 Is there someone at home able to take care of you? Yes No
 Alcohol: Social Drinker Heavy Drinker Occasional Never Tobacco: Number of packs per day _____
 How much time have you lost from work due to health problems during the past 6 months? _____ 1 yr. _____ 3 yrs. _____

FAMILY HISTORY – HAS ANY BLOOD RELATIVE EVER HAD ANY OF THE FOLLOWING

	Yes	No		Yes	No		Yes	No		Yes	No
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Tendencies	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>			
Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>	Suicide	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Condition	<input type="checkbox"/>	<input type="checkbox"/>			

ALLERGIES AND MEDICATIONS

Do you have any allergies to medications? Yes No Any other medically related allergies? Yes No
 If yes, please specify: _____
 Are you currently taking any medication? Yes No
 If yes, what type(s): _____

PERSONAL HISTORY – HAVE YOU EVER HAD ANY OF THE FOLLOWING (PLEASE ANSWER YES OR NO TO ALL QUESTIONS)

	Yes	No		Yes	No
1. Frequent or severe headache	<input type="checkbox"/>	<input type="checkbox"/>	21. Abnormal blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
2. Dizziness or fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	22. Heart problem or murmur	<input type="checkbox"/>	<input type="checkbox"/>
3. Eye problem	<input type="checkbox"/>	<input type="checkbox"/>	23. Excessive bleeding	<input type="checkbox"/>	<input type="checkbox"/>
4. Ear, nose, or throat problem	<input type="checkbox"/>	<input type="checkbox"/>	24. Anemia or other blood condition	<input type="checkbox"/>	<input type="checkbox"/>
5. Chest or lung problem	<input type="checkbox"/>	<input type="checkbox"/>	25. Clots in legs or vein problem	<input type="checkbox"/>	<input type="checkbox"/>
6. Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	26. Stomach, liver, or intestinal problems	<input type="checkbox"/>	<input type="checkbox"/>
7. Swelling of extremities / shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	27. Hepatitis, jaundice, or gall bladder problem	<input type="checkbox"/>	<input type="checkbox"/>
8. Pain or pressure in chest	<input type="checkbox"/>	<input type="checkbox"/>	28. Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
9. Palpitation or pounding heart	<input type="checkbox"/>	<input type="checkbox"/>	29. Urinary, kidney, bladder, or prostate problem	<input type="checkbox"/>	<input type="checkbox"/>
10. Tumor, growth, or cancer	<input type="checkbox"/>	<input type="checkbox"/>	30. Muscle weakness / atrophy	<input type="checkbox"/>	<input type="checkbox"/>
11. Recent gain or loss of weight over 10 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	31. Neuromuscular / neurological problems	<input type="checkbox"/>	<input type="checkbox"/>
12. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	32. Drinking dependency / disorder	<input type="checkbox"/>	<input type="checkbox"/>
13. Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	33. Drug dependency / disorder	<input type="checkbox"/>	<input type="checkbox"/>
14. Measles, mumps, or chicken pox	<input type="checkbox"/>	<input type="checkbox"/>	34. Psychological problems	<input type="checkbox"/>	<input type="checkbox"/>
15. Scarlet or rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	35. Surgeries / serious illness	<input type="checkbox"/>	<input type="checkbox"/>
16. Arthritis, gout, or rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	36. Notable accidents / injuries	<input type="checkbox"/>	<input type="checkbox"/>
17. Fractures, sprains, or dislocations	<input type="checkbox"/>	<input type="checkbox"/>	37. Skin diseases	<input type="checkbox"/>	<input type="checkbox"/>
18. Painful or swollen joints	<input type="checkbox"/>	<input type="checkbox"/>	38. Pregnant / possibly pregnant	<input type="checkbox"/>	<input type="checkbox"/>
19. Bone infections	<input type="checkbox"/>	<input type="checkbox"/>	39. Obstetrical disorders	<input type="checkbox"/>	<input type="checkbox"/>
20. Taken steroids	<input type="checkbox"/>	<input type="checkbox"/>	40. Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>

Please explain any yes answers. Be sure to number each explanation with the item number.

Other medical problems: _____
 Past surgeries: _____
 Part of body injured or effected: _____ Right Left
 When and how did this occur: _____
 Any surgery for current problem? Yes No If yes, please specify: _____