STEINDLER ORTHOPEDIC CLINIC
Excellence in Motion

PAST MEDICAL INFORMATION

Today's Date _____

Name of Patient _____ Age _____ Sex _____ Birth Date _____

Medical Conditions: (check if applicable)

- ❑ Diabetes
- ❑ Hypertension
- ❑ High Cholesterol
- ❑ Heart Disease
- ❑ Cancer
- ❑ Osteoporosis
- ❑ DVT/PE
- ❑ Hypothyroidism

IMPORTANT: CHECK AND/OR LIST ALL YOUR MEDICAL CONDITIONS

All other medical conditions not listed: _____

_____

_____

_____

List Your Medications: _____

Are you **allergic** or **sensitive** to any medications or other substances? ❑ Yes ❑ No ❑ Metals ❑ Latex

If so, please list allergy and reaction: _____

Have you ever had general anesthesia? ❑ Yes ❑ No

Have you or your family ever had any problems with anesthesia? ❑ Yes ❑ No

Past Surgical History: Have you ever been operated on for any condition? ❑ Yes ❑ No

Procedure	Date	Procedure	Date
Orthopedic		Hernia Repair	
Tonsillectomy		Gall Bladder	
Cataracts		Hysterectomy	
Appendectomy		C Section	
Bladder/Prostate		Cardiac/Bypass Surgery/Heart Catheter	
Other		Other	

Review of Symptoms

Are you (or the child) having or have you had the following symptoms or problems with: **check symptom if applicable or check None**

Constitutional:	❑ None ❑ Fatigue ❑ Fever ❑ Weight Loss ❑ Chills ❑ Sweating
Eyes:	❑ None ❑ Blurred Vision ❑ Glasses ❑ Watering Eyes
Ear/Nose/Mouth/Throat:	❑ None ❑ Sinus Pressure ❑ Hearing Loss ❑ Nose Bleeds ❑ Sores in Mouth
Respiratory:	❑ None ❑ Shortness of Breath ❑ Wheezing ❑ Cough ❑ Coughing up Blood
Cardiovascular:	❑ None ❑ Chest Pain ❑ Palpitations ❑ Tightness in Chest ❑ Swelling
Gastrointestinal:	❑ None ❑ Nausea ❑ Vomiting ❑ Constipation ❑ Diarrhea ❑ Change in Bowel Habits
Genitourinary:	❑ None ❑ Urinary Tract Infection ❑ Difficulty Urinating ❑ Incontinence ❑ Loss of Sensation near groin/buttocks
Endocrine:	❑ None ❑ Heat or Cold Intolerance ❑ Excessive Thirst ❑ Excessive Urination
Musculoskeletal:	❑ None ❑ Joint Pain ❑ Leg Pain ❑ Joint Stiffness ❑ Back Pain ❑ History of broken bones
Hematologic/Lymphatic:	❑ None ❑ Anemia ❑ Bruises Easily ❑ Enlarged Glands ❑ Prolonged bleeding after cut/injury
Neurologic:	❑ None ❑ Numbness/tingling ❑ Dizziness ❑ Headaches ❑ Frequent Falls
Integumentary/Skin:	❑ None ❑ Rashes ❑ Change in Skin Color
Psychiatric:	❑ None ❑ Change in Mood ❑ Anxiety ❑ Confusion ❑ Depression ❑ Memory Loss
Allergies/Immunologic:	❑ None ❑ Asthma ❑ Chronic Rashes ❑ Hay Fever

Social History

Occupation: _

Do you currently smoke? ❑ Yes ❑ No Have you ever smoked? ❑ Yes ❑ No If yes, how long ago did you quit? _____

Do you consume any alcohol? ❑ Yes ❑ No If yes, how often? _____

❑ Single ❑ Married ❑ Divorced ❑ Widowed # of children _____

Is there a family history of: ❑ High Blood Pressure ❑ Heart Disease ❑ Diabetes ❑ Cancer ❑ Hyperthermia ❑ DVT/PE ❑ None

I certify to the best of my knowledge that the above information is correct.

Patient/Guardian Signature _____ reviewed _____

Date _____ _____

I have reviewed and agree with the findings as noted. Physician Signature _____ _____