MILLSAP VALLEY
ORTHOPAEDICS
& SPORTS MEDICINE

Patient Medical History

Name _____ Date _____

Height _____ Weight _____

Please circle Yes/No and describe as appropriate.

Unexplained Fever, Weight Loss Y / N _____
Problems with Eyes, Ears, Nose, Mouth, Throat Y / N _____
Heart Disease or High Blood Pressure Y / N _____
Respiratory or Asthma Y / N _____
Gastrointestinal or Ulcers Y / N _____
Kidney, Bladder, or Prostate Y / N _____
Musculoskeletal, Arthritis, Lyme Disease Y / N _____
Skin or Breast Problems Y / N _____
Neurological or Psychiatric Y / N _____
Diabetes or Thyroid Y / N _____
Cancer or Blood Disease Y / N _____
Are you on disability Y / N _____
Any other medical condition _____
Last Check Up _____

Medications and Dosages _____ _____

_____ _____ _____

_____ _____ _____

Birth Control _____
Allergies and Drug Reactions _____

_____

Previous Surgery and Hospitalization with dates _____

_____

Recent Illness', Infections _____

Alcohol Usage _____ Tobacco Usage _____ Drug Usage _____
Any Diseases run in the family? _____

RATE YOUR PAIN (0-10) _____