MEDICAL HISTORY FORM  **TEXAS HIP & KNEE CENTER**

Name:_____ **Today's Date:** _____

Height:_____ **Weight:**_____ **Date of Birth/Age:** _____

Name of your primary care physician:_____ **Phone:** _____

CHIEF COMPLAINT

Why are you seeing the doctor today: _____

Is Current problem the result of a(n): **Check all that apply**

☐ Car Accident ☐ Work Accident ☐ Accident ☐ Other

Current Medications	Dose	Reason for Medication	Side Effects
List Additional on back of form			

ALLERGIES: Medications:

Are all immunizations up to date? ☐ Yes ☐ No If no, which immunizations are due? _____

Do you now or have you ever taken Prednisone or Steroids? Yes____ No _____

Do you have any of the following:

Metal or jewelry allergies? Yes___ No____ What type of Metals? _____

Solution Allergies? Yes____ No____ What type of Solution? _____

Tape Allergies? Yes____ No____ What type of tape/Band-Aids? _____

Latex Allergies? Yes____ No____

Medical History:

Are you currently having or have you had problems with your:

	Circle		Describe all "yes" responses
Eyes	No	Yes	
Lungs, breathing/Emphysema	No	Yes	
Asthma or Hayfever	No	Yes	
Bowel problems	No	Yes	
Bladder/urinary infections	No	Yes	
Diabetes (high blood sugar)	No	Yes	
High blood pressure	No	Yes	
Bleeding or Circulatory problems	No	Yes	Describe:
Balance problems	No	Yes	
Numbness/tingling	No	Yes	
Blackout/fainting	No	Yes	
Psychological/Depression	No	Yes	
AIDS	No	Yes	
Cancer	No	Yes	Type: Treatment Type:
Hepatitis	No	Yes	Type: A B C
Tuberculosis (TB)	No	Yes	
Neurological/Epilepsy	No	Yes	

Patient Signature: _____ **Date:** _____

Reviewed By: _____ **MD** **Date:** _____

Name: _____ **Today's Date:** _____

SSN: _____ **Date of Birth/Age:** _____

Medical History Continued:

Stomach ulcers	No	Yes	_ _____
Difficulty tolerating fatty foods	No	Yes	_____
Liver Disease	No	Yes	_____
Congestive Heart Failure or Heart Attack	No	Yes	Name & phone number of Cardiologist: _____ _____
Angina	No	Yes	Name of Medication: _____
Stroke	No	Yes	_____
Low back pain	No	Yes	History of Back problems? _____
Blood clots, Phlebitis	No	Yes	_____
Prostate Disease	No	Yes	_____
Female organs/menstrual	No	Yes	_____
Chronic Infections	No	Yes	Site of infection: _____
Arthritis	No	Yes	Rheumatoid? _____
Gout	No	Yes	_____
Thyroid Disease	No	Yes	_____
Skin: Rashes, infections psorias	No	Yes	_____

PAST SURGICAL/HOSPITALIZATION HISTORY- (For previous orthopaedic surgeries, please list surgeons name and year of surgery)

Surgeries / Hospitalizations	Year	Complications

Have you ever had general anesthesia?(Being put to sleep for an operation) **No** **Yes**

Have you ever had problems with anesthesia? **No** **Yes** **Describe:** _____

FAMILY HISTORY

Member	Alive	Deceased	Age	Health status or cause of death
Father	A	D		
Mother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		

Patient Signature: _____ **Date:** _____

Reviewed By: _____ **MD** **Date:** _____

Name:_____ **Today's Date:** _____

SSN: _____ **Date of Birth/Age:** _____

SOCIAL HISTORY

☐ Work in the home ☐ Employed (occupation_____) ☐ Student ☐ Retired
☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed Children?

☐ No ☐ Yes

Do you live alone? ☐ No ☐ Yes If yes, do you have help or family near by? ☐ Yes ☐ No

Exercise? ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never
What type of exercise? _____

History of substance abuse? ☐ No ☐ Yes What? _____

Smoke currently? ☐ No ☐ Yes ____ Packs per day for ____ years.
Quit smoking ☐ This year ☐ >1 year ☐ >5 years ☐ >10 years Previously smoked ____ packs per day for ____ years.

Drink alcohol? ☐ Daily ☐ 1-2 x/week ☐ 1-2 x/month ☐ 1-2 x/year ☐ None

Please use the space below to make comments regarding any health issues not covered by our forms:

Patient Signature: _____ **Date:** _____

Reviewed By: _____ **MD** **Date:** _____