Taos Orthopaedic Institute

Patient Name_____ Medical Record Number_____

REVIEW OF SYSTEMS: Do you have now, or have you ever had, any of the following health problems?

1) M/S *Have you had a prior problem with this same Orthopaedic condition in the past? ☐ Yes ☐ No (explain below)

_____

* Have you had prior ☐ Back Pain ☐ Joint Swelling ☐ Prior Fracture ☐ Arthritis

2) ARE YOU ALLERGIC TO ANY MEDICATIONS? ☐ **Yes** ☐ **No** If **yes,** please list_____

_____

3) **ARE YOU A DIABETIC?** ☐ **Yes** ☐ **No** **TREATMENT:** ☐ Insulin ☐ Oral Meds ☐ Diet ☐ None

(Please check any that apply, or mark None)	**None**	**Year**	**Explain Details/Comments**
4) CON ☐ weight loss ☐ loss of appetite ☐ Fever ☐ Cancer			
4) **EYE** ☐ Glasses ☐ Contacts ☐ Double Vision ☐ Cataract			
5) ENT ☐ Hearing loss ☐ Hoarseness ☐ Ringing in Ears			
6) CV ☐ High Blood Pressure ☐ Heart Attack ☐ Blood Clots			
7) RS ☐ Asthma ☐ Cough ☐ Pneumonia ☐ Short of Breath ☐ TB			
8) GI ☐ Stomach Ulcer ☐ Hepatitis ☐ Blood in Stool			
9) GU ☐ Pain with Urination ☐ Blood in Urine ☐ Kidney Disease			
10) SK ☐ Skin Ulcers ☐ Rash ☐ Lumps			
11) NEU ☐ Seizures ☐ Stroke ☐ Balance Problem ☐ Headaches			
12) PSY ☐ Depression ☐ Nervousness ☐ Sleep disorder			
13) HEM ☐ Easy Bleeding ☐ Easy Bruising ☐ Anemia			

15) In the event that you are referred to have an MRI (Magnetic Resonance Imaging) do you have any of the following? (Cardiac pacemaker, brain vessel clips. Aorta clips, metal fragments in your head, eye or skin, and have you ever worked with metal as a metal worker?) ☐ **Yes** ☐ **No**

PAST MEDICAL HISTORY

WHAT MEDICATIONS DO YOU TAKE? ☐ None Please list with dosage:_____

_____

_____

PAST HOSPITALIZATIONS (Not for surgery) ☐ None _____

PAST SURGICAL HISTORY: What operations have you had? When? ☐ None_____

Are you taking, or have you ever taken, blood thinners? ☐ Yes ☐ No If yes, what type?_____

Have you ever had a reaction to anesthesia? ☐ Yes ☐ No

FAMILY HISTORY: Have any direct relatives had any of the following disorders? If so, which relative?

- Any direct relative with the same Orthopaedic condition you are being seen for today? ☐ Yes ☐ No _____

Diabetes ☐ Yes ☐ No _____ High Blood Pressure ☐ Yes ☐ No_____Heart Disease ☐ Yes ☐ No_____

Arthritis ☐ Yes ☐ No _____

SOCIAL HISTORY:

Do you use tobacco? ☐ Yes ☐ No Packs per day _____Alcohol use? ☐ Yes ☐ No How often? ☐ Daily Other___/week

Marital History : M S D W How many people live with you? _____

Occupation:_____ ☐ Student Employer:_____

Are you currently working? ☐ Yes ☐ No If no, how long have you been off work?_____

Patient Signature_____ **Date**_____

_____

For Office Use only

Reviewed for completeness by _____ Date__/__/__ Reviewed by MD_____ Date__/__/

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