



**Medical Group**

**Medical History**

Do you have any allergies? Yes No

List each allergy and reaction: \_\_\_\_\_

List all medications including over-the-counter medications, vitamins, and hormone therapy:

Do you- Smoke: Y/N How often? \_\_\_\_\_ Drink: Y/N How often? \_\_\_\_\_ Do Drugs: Y/N How Often? \_\_\_\_\_

Do you have any of the following medical conditions? (please check all applicable boxes below)

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Anemia or blood disorders  | <input type="checkbox"/> Diabetes<br>- If so, do you take insulin? Yes No | <input type="checkbox"/> High blood pressure   |
| <input type="checkbox"/> Arthritis  | <input type="checkbox"/> Epilepsy or seizure disorders                    | <input type="checkbox"/> Kidney or liver disorders                                     |
| <input type="checkbox"/> Asthma   | <input type="checkbox"/> Gout   | <input type="checkbox"/> Lung disease or COPD  |
| <input type="checkbox"/> Blood clot, deep vein thrombosis (DVT), or pulmonary embolism (PE) | <input type="checkbox"/> Heart disease or high cholesterol                | <input type="checkbox"/> Stomach or gastrointestinal problems, GERD, reflux, or ulcers |
| <input type="checkbox"/> Cancer<br>- If so, what type? _____                                | <input type="checkbox"/> Heart attack or stroke<br>- If so, when? _____   | <input type="checkbox"/> Thyroid disorders   |
| <input type="checkbox"/> Other: _____   |   |  |

Do you have: Sickle Cell Disease Trait-Patient \_\_\_\_\_ Sickle Cell Disease Trait-Family \_\_\_\_\_

Have you had any recent acute inflammatory processes or infections, such as inflammatory bowel disease, cellulitis, pneumonia, or sepsis? Yes No

Is there a family history for any of the above medical condition(s) (mother, father, siblings ,and /or grandparents)? Yes No

Please identify which medical condition(s) and which family member(s): \_\_\_\_\_

Did you ever have minor or major surgery? Yes No Have you had surgery in the past month? Yes No

What type(s) or surgery did you have? \_\_\_\_\_

**General Patient Information**

YOUR MARITAL STATUS (please circle below)

SINGLE MARRIED SEPARATED DIVORCED WIDOWED

Do you have children? Yes No How many? ( ) Are you pregnant? Yes No

Who is your Primary Care Physician (PCP) or Referring Physician?

Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone(\_\_\_\_\_) \_\_\_\_\_

If a physician did not refer you, who referred you to ENHMG Orthopaedic Surgery? \_\_\_\_\_

**When finished completing the questionnaire, please return to the front desk staff. Thank you.**

