Name: _____ DOB: _____

Medical History

Wilson Orthopaedics & Sports Medicine

Procedure	Date	Procedure	Date
Heart Cauterization		Gallbladder	
C Section		Neck	
Tonsillectomy		Back	
Appendectomy		Knee	
Arterial		Hip	
Hysterectomy		Pacemaker	

Other_____

Reason for today's visit: _____

Current Medication

Medication	Dose (mg)	Times per day

Are you allergic to anything? (Medications, Pollen, Animals) YES NO

If YES, please list_____

NAME: _____

DOB: _____

PLEASE SELECT ALL THE FOLLOWING CONDICTIONS THAT APPLY TO YOU OR A FAMILY MEMBER

	Self	**family**		**Self**	**family**
Acid Reflux			Heart Disease		
ADD or ADHD			Hernia		
Anemia			High Blood Pressure		
Anesthesia Complications			High Cholesterol		
Anxiety disorder			Hypertension		
Arthritis			Hyperthyroidism		
Asthma			Kidney Disease		
Birth Defect			Kidney Stones		
Bladder/Kidney Problems			Liver Disease		
Blood Clots			Lung Disease		
Blood Disease			Muscle/Joint/Bone Problems		
Cancer			Peripheral Vascular Disease		
Chicken Pox			Psychiatric Illness		
Congenital Anomalies			Pulmonary Embolism		
Constipation			Nausea		
COPD			Seizures/Epilepsy		
Coronary Artery Disease			Shortness of Breath		
Depression			Stomach Ulcers		
Diabetes			Stroke		
Ear/Hearing Problems			Thyroid Problems		
Endometriosis			Tuberculosis		
Fibromyalgia			Varicose Veins		
GERD/Reflux			Vision/Eye Problems		
GI Problems			Glaucoma		
Gout			Vomiting		
Headaches					

NAME: _____

DOB: _____

SMOKING STATUS:

Never___ Former___ Current everyday___ Current someday ___

How Much? _____packs/day How long? _____

Are you able to Self Care? Yes___ no ___

Alcohol Intake: None ___ Occasional ____ Moderate ___ Heavy ___

Caffeine Intake: None ___ Occasional ____ Moderate ___ Heavy ___

Illicit drugs? YES ___ None ____

Hand Dominance: LEFT ___ RIGHT ___ BILATERAL ___

Is blood transfusion acceptable in an EMERGENCY? YES ___ NO ___

Do you have an Advance Directive? YES ___ NO ___

Do you have Home Health? Company? _____

Have you seen an Orthopaedic doctor for this condition? _____

Was this injury work related? YES ___ NO ___

Is there an attorney involved? YES ___ NO ___

PHARMACY YOU PREFER _____

HEIGHT _____ WEIGHT _____

What are we seeing you for today? _____ LEFT SIDE RIGHT SIDE

PAIN LEVEL NOT AT ALL 1 2 3 4 5 6 7 8 9 10 WORST PAIN

Signature: _____Date: _____