The Orthopaedic Specialists of South Texas

INNOVATIVE. EXCELLENT. CARE.

Date: ___ / ___ /___ ☐ New Patient ☐ Current Patient

MEDICAL HISTORY

Name: (Last) _____ (First) _____ (Middle) _____

1. Medical Problems:
   Do you have:
   High Blood Pressure ☐ No ☐ Yes ☐ Unsure
   Diabetes ☐ No ☐ Yes ☐ Unsure
   Please list any other medical conditions you may have: _____
   _____
   _____

2. Review of Systems:
   Do you suffer from:
   Chest Pain ☐ No ☐ Yes
   Shortness of breath ☐ No ☐ Yes
   Gastrointestinal or Urologic problems ☐ No ☐ Yes
   Unintended weight loss ☐ No ☐ Yes
   Fever ☐ No ☐ Yes
   Chills ☐ No ☐ Yes
   Open Wound ☐ No ☐ Yes
   Drainage ☐ No ☐ Yes
   Please list any other medical conditions you may have:_____
   _____
   _____

3. List any surgeries you have had: _____
   Did you have any complication with anesthesia? ☐ No ☐ Yes
4. Last Tetanus: ☐ Less than 5 years ago ☐ More than 5 years ago
5. Medications:
   Are you taking blood thinners? ☐ No ☐ Yes
   Please list any other medications you are taking:
   _____
   _____
   Do you have any drug allergies? ☐ No ☐ Yes ☐ Unsure
   If yes, please list:
   _____
   _____
6. Do you smoke? ☐ No ☐ Yes If yes, how many years? _____ How much? _____
7. Do you drink alcohol? ☐ No ☐ Yes If yes, how much?
   _____
8. Is there any family history of anesthetic complication? ☐ No ☐ Yes
9. Please list any family medical problems: _____