

Beth Israel Medical Center
Department of Orthopaedic Surgery

Medical Information
 2 pages

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|-------------|------------|
| Name | Age |
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History - What are your symptoms? When did they begin? What treatments have you had?

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What physicians have you seen? What treatments have you had?

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Occupation: _____ **Height:** _____ **Weight:** _____

Regular sports activities: _____

Marital status : SINGLE MARRIED DIVORCED WIDOW/WIDOWER

Which hand do you use to write? RIGHT LEFT

Do you smoke? YES NO If yes: Packs per day _____, Years smoked _____

How often do you drink alcohol? NEVER WEEKLY DAILY

Do you have any history of substance abuse? YES NO

Medical problems - To the best of your knowledge, have you ever been diagnosed with any of the following conditions? *Please circle one for each.*

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|---------------------------------|-----|----|
| High blood pressure | YES | NO |
| Heart disease | YES | NO |
| Lung disease | YES | NO |
| Cancer | YES | NO |
| Diabetes | YES | NO |
| Liver disease | YES | NO |
| Hepatitis | YES | NO |
| Bladder or kidney problems | YES | NO |
| Stomach or intestinal disorders | YES | NO |

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|-------------------------------|-----|----|
| Sexually transmitted diseases | YES | NO |
| Tuberculosis | YES | NO |
| Immune disorders | YES | NO |
| Epilepsy or stroke | YES | NO |
| Thyroid disease | YES | NO |
| Blood disorders | YES | NO |
| Skin rashes or disorders | YES | NO |
| Osteoporosis | YES | NO |
| Psychological problems | YES | NO |

If you answered YES to any of the above, please describe below.

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For females: **Number of pregnancies:** _____ **Do you menstruate currently?** YES NO

Operations - Please list all with dates

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Medications - Please list all that are taken regularly

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Allergies to food or medicines - Please list all

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Family history - List any medical problems of close blood relatives (parents, siblings, children)

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Emergency Contact information

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|------------|------------|------------|--|
| Name | | Relation | |
| Home Phone | Work phone | Cell/pager | |

MD ONLY

M.D. Signature