MINOR & JAMES
MEDICAL
SWEDISH Health Partner

Orthopedics & Podiatry Medical History – Please Print

Name_____ D.O.B._____ Age_____ Sex ☐Male ☐Female

Height_____ Weight_____ Primary Care Physician_____

Marital Status: ☐Single ☐Married ☐Partnered ☐Divorced ☐Widowed

Chief Complaint_____ Side of Body: ☐Right ☐Left Onset Date_____

☐No Injury ☐Injury non-auto or work related ☐Work related ☐Auto related

Are you: ☐Right hand dominant ☐Left hand dominant ☐Both

Current occupation_____

Do you have or have you ever had:

	Yes	No	Explain		Yes	No	Explain
Heart Trouble				Kidney Problems			
High Blood Pressure				Bladder Infections			
Stroke				Difficulty in Urination			
Blood Clots				Prostate Problems			
Anemia				Ulcer/Gastritis			
Bruising/Bleeding				Liver Problems			
Asthma				Hepatitis			
Emphysema				Seizures			
Tuberculosis				Psychiatric Care			
Diabetes				Depression			
Glaucoma				Arthritis			
Vision Problems				Cancer			
Sleep Apnea				Thyroid Disorder			
Dizziness				Other			
Headaches							
Numbness/Tingling							

Do You:

Have a family history of Diabetes, Cancer, Heart Disease, or other disease? ☐Yes ☐No

Disease: _____ Relationship: _____

Does anyone in your family have any orthopedic conditions related to your chief complaint? ☐Yes ☐No

Disease: _____ Relationship: _____

Smoke: ☐Yes ☐No If yes, how much? _____ How long?_____

Drink alcohol: ☐Yes ☐No If yes, how much? _____

Previous Operations & Dates: Please use the back for additional space

a) _____ d) _____

b) _____ e) _____

c) _____ f) _____

Have you ever had any problems with surgery or anesthesia? _____

Drug Allergies: a) _____ b) _____ c) _____

Reactions: a) _____ b) _____ c) _____

Current Medications: Please use the back for additional space

a) _____ d) _____

b) _____ e) _____

c) _____ f) _____

Patient Signature_____

Date_____

Physician's Signature_____

Date_____