

Initial Patient Medical History Summary

David A. McGuire, MD

Alaska Orthopaedic Specialists

Patient Name: _____ DOB: _____ Sex: M F Chart# _____

Weight: _____ Height: _____ BP _____ Pulse _____ Pulse Ox _____ Temp _____

Check any past/current problems:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Confused | <input type="checkbox"/> Vision | <input type="checkbox"/> Abnormal Pap smears | <input type="checkbox"/> Difficulty walking |
| <input type="checkbox"/> Unresponsive | <input type="checkbox"/> Loose/chipped teeth | <input type="checkbox"/> Reproductive organs | <input type="checkbox"/> Frequent falls |
| <input type="checkbox"/> Eyes | <input type="checkbox"/> Capped/false teeth | <input type="checkbox"/> Dialysis | <input type="checkbox"/> Bones |
| <input type="checkbox"/> Ears | <input type="checkbox"/> Circulation problems | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Nose | <input type="checkbox"/> Stomach problems | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Immune system problems |
| <input type="checkbox"/> Mouth | <input type="checkbox"/> Weight loss | <input type="checkbox"/> Blood clots | <input type="checkbox"/> Too little sleep |
| <input type="checkbox"/> Sinus | <input type="checkbox"/> Weight gain | <input type="checkbox"/> Bleeding | <input type="checkbox"/> Too much sleep |
| <input type="checkbox"/> Throat | <input type="checkbox"/> Bowel problems | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Lung problems |
| <input type="checkbox"/> Skin problems | <input type="checkbox"/> Liver problems | <input type="checkbox"/> Stroke | <input type="checkbox"/> Breathing problems |
| <input type="checkbox"/> Rash | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Chronic cough |
| <input type="checkbox"/> Hives | <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Seizures | <input type="checkbox"/> TB |
| <input type="checkbox"/> Hearing | <input type="checkbox"/> Kidney | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Positive TB test |
| <input type="checkbox"/> Speech | <input type="checkbox"/> Pain: | <input type="checkbox"/> Cancer: | <input type="checkbox"/> Other: _____ |

Implants/surgical or other metal inside the body: type _____ location _____

Problems with anesthesia, describe _____

Explain any checked items _____

List any previous hospitalizations/surgeries/invasive procedures: _____ Year _____

_____ Year _____

List any allergies _____

Medications _____

Family History

Father: living dead age of death _____ cause of death _____

Mother: living dead age of death _____ cause of death _____

Have you had a family member with any of the ***following***? If so, check the appropriate Box.

	Father	Mother	Children	Sibling	Grandparent	Father	Mother	Children	Sibling	Grandparent
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Migraine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	TB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	disease				

Social History

Marital Status: Married Single Divorced Separated Widow

Children YES OR NO (circle one)

Do you live alone? yes no If you needed help to care for yourself, is there someone available to help you? yes no

Tobacco: yes no If yes, how much/day _____ x _____ years _____ Recreational drugs? yes no

Alcohol: yes no, If yes, how much _____ / day _____ / week.

Caffeine: yes no, If yes, how much _____ Exercises routine: _____

Occupation: _____

Unusual dietary habits or herbal supplements: _____

Do you have an advanced directive? yes no

If yes, living will Durable power of attorney Health care directive

Patient signature: _____ Date: _____

Clinical review: date / initials _____