MONADNOCK ORTHOPAEDIC ASSOCIATES

YOUR NAME _____ TODAYS DATE: _____

*You are asked to complete this form in **FULL** if you are new to the practice or update your form if it has been over 6 months since your last visit. **ALL** information is confidential &**VERY** important to your care.*

THANK YOU FOR CHOOSING M.O.A.!

Personal Medical History:

Condition:	**Yes √**	**No √**		**Yes √**	**No √**
Heart Problems (**what type**?)			High Blood Pressure		
Stroke/ TIA			Sugar Diabetes Type I or II		
Neurological Problems			Thyroid Problems		
Epilepsy/ Seizures			Osteoporosis/ Thin Bones		
Stomach Ulcers			Osteoarthritis or Rheumatoid Arthritis		
Gastric Reflux (GERD)			Metal in body? Pacemaker?		
CANCER (**type?)**			Problems with Anesthesia (**what?)**		
Hepatitis A, B, C/Liver Disease			Lung Problems/ COPD/ Asthma		
Kidney Problems (**type?)**			Sleep Apnea		
Anxiety or Depression			Cholesterol		
Blood/Bleeding Disorder			Other Medical Conditions: **(List)**		

Family Medical History: Father (Alive or Deceased?) Age ____ Mother (Alive or Deceased?) Age ____

Condition:	**Yes √ Who?**	**No√**		**Yes √ Who?**	**No √**
Heart Problems (**what type**?)			High Blood Pressure		
Stroke/ TIA			Sugar Diabetes Type I or II		
Neurological Problems			Thyroid Problems		
Epilepsy/ Seizures			Osteoporosis/ Thin Bones		
Stomach Ulcers			Osteoarthritis		
Gastric Reflux (GERD)			Rheumatoid (Inflammatory) Arthritis		
CANCER (type?)			Total Joint Replacement		
Hepatitis A, B, C/Liver Disease			Lung Problems/ COPD /Asthma		
Kidney Problems			Problems with Anesthesia		
Anxiety or Depression			Sleep Apnea		
Blood/Bleeding Disorder					
Other Familial Medical Conditions: **(List)**					

Social History:

Your Occupation:	Highest Education Level:
Live alone or with others?	Alcohol intake? (**amount**)
Single/ Married/ Divorced?	Tobacco History?Packs per day _____ years ____
Stairs at home?	Do you still smoke? _____ When Quit?_____
Leisure/Sporting Activities?	Recreational Drug use? Yes/ No

MONADNOCK ORTHOPAEDIC ASSOCIATES

Surgical History: (please CIRCLE and DATE)

Tonsils/ Adenoids	Nasal/ Oral
Appendix	Tubes/ Vasectomy
Gallbladder	Bladder Suspension
Hysterectomy/Ovaries	Prostate Removal
Cardiac Surgery: (List)	Lung Surgery: (List)
Vascular: Stent/ Artery Bypass/ Vein Stripping	Major Abdominal: Liver/ Kidney/ Bowel
Hernia Repair	Plastic Surgery: (List)
Cancer Surgery	Prior anesthetic reactions?
Other Surgery: (List)	

Orthopaedic Conditions:

	Type/Date/Age/Complications?
Fractures	
Injuries	
Joint Replacements	
Other:	

Medications: (List name and dose or provide copy of medication list to the MD/Nurse)

	Supplements/vitamins?
	Over the counters?

DO YOU HAVE MEDICATION OR DRUG ALLERGIES? *Rash/Hives/Breathing problem/Nausea?*
NO/ YES **(list)** _____
_____

DO YOU HAVE ANY OF THESE PROBLEMS? Elaborate whenever possible

Symptom:	**Yes √**	**No√**		**Yes √**	**No √**
Appetite/Weight loss			Abnormal Lymph Nodes		
Poor sleep (why?)			Chest Pains		
Breathing Difficultly			Uncorrected Vision Problems		
Blood Condition (what?)			Skin Conditions (what?)		
Bladder Problems (what?)			Morning Stiffness (where?)		
Bowel Problems (what?)			Food Allergies (what?)		
Night Sweats or Chills			Immunity Problems (what?)		
Unexplained Fevers			Bruising or Clotting Problems		
Dizziness or Poor Balance			Currently Depressed		
			Problems with Anxiety		
Other Joint or Muscle problems: **(List)**					

Provider Signature_____ Date reviewed _____