

STEAMBOAT ORTHOPAEDIC ASSOCIATES, P.C.

PATIENT MEDICAL INFORMATION

Patient Name: _____ DOB: _____

Family Physician: _____ Today's Date: _____

PAST MEDICAL HISTORY/PROBLEM LIST:

- Checkboxes for various medical conditions: Aids, Alcoholism, Anemia, Arrhythmias, Arthritis, Bleeding Disorders, Blood Clots, Bronchitis, Cancer, Chemical Dependency, Coumadin Treatment, Dental Problems, Diabetes, Emphysema, Epilepsy, Esophageal Reflux, Heart Disease, Hepatitis Type, High Blood Pressure, High Cholesterol, Kidney Disease, Liver Disease, Migraine HA, Multiple Sclerosis, Oxygen Use, Pacemaker, Polio, Prostate Problems, Rheumatic Fever, Sleep Apnea, Stroke, Thyroid Problem, Ulcers.

OTHER MEDICAL PROBLEMS NOT LISTED ABOVE: _____

SOCIAL HISTORY:

☐ Tobacco --- Packs Per Day _____ ☐ Alcohol --- Amount: _____

MEDICATIONS: List medications you are currently taking.

Three sets of horizontal lines for listing medications.

Pharmacy Preference: _____

ALLERGIES: List allergies AND their adverse reaction.

Two sets of horizontal lines for listing allergies and reactions.

SURGERY HISTORY: Provide year of surgery.

Two sets of horizontal lines for listing surgery history.

FAMILY HISTORY: Please provide Age and Medical Health History.

Father: _____ Mother: _____

Siblings/Other family members: _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of Patient, Parent, Guardian or Representative

Please print name (if different from patient)