ORTHOPAEDIC & SPORTS MEDICINE CENTER OF MIAMI

PATIENT'S MEDICAL HISTORY – AS OF _____

PATIENT NAME: _____ DOB: _____

PERSONAL HISTORY		FAMILY HISTORY		
High Blood Pressure	___	High Blood Pressure	___	Mother/Father
Heart Problem	___	Heart Problem	___	Mother/Father
Urinary Problems	___	Urinary Problems	___	Mother/Father
Kidney Problems	___	Kidney Problems	___	Mother/Father
Tuberculosis	___	Tuberculosis	___	Mother/Father
Intestinal/Stomach Problem	___	Intestinal/Stomach Problem	___	Mother/Father
Thyroid Problem	___	Thyroid Problem	___	Mother/Father
Respiratory Problem	___	Respiratory Problem	___	Mother/Father
Neurological Problem	___	Neurological Problem	___	Mother/Father
Diabetes	___	Diabetes	___	Mother/Father
Stroke	___	Stroke	___	Mother/Father
Gout	___	Gout	___	Mother/Father
Bleeding Ulcer	___	Bleeding Ulcer	___	Mother/Father
Bleeding Disorders	___	Bleeding Disorders	___	Mother/Father
Anemia	___	Anemia	___	Mother/Father
Phlebitis	___	Phlebitis	___	Mother/Father
Arthritis	___	Arthritis	___	Mother/Father
Cancer	___	Cancer	___	Mother/Father
Asthma	___	Asthma	___	Mother/Father
Migraine	___	Migraine	___	Mother/Father
Pacemaker	___	Pacemaker	___	Mother/Father

Do you Smoke? Yes / No Socially Drink? Yes / No Left or Right handed? Left / Right

Are you allergic to any medications? If so, which medications? _____

_____

Yes / No _____

Are you currently taking any medication? If so, list them: _____

_____

Yes / No _____

Have you ever had any Fractures or Dislocations? Yes / No

Which part of the Body?	When?	Did you have Surgery?
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever had any Surgeries or Procedures done? Yes / No

Which part of the Body?	When?	Who was your surgeon?
_____	_____	_____
_____	_____	_____
_____	_____	_____

Female Patients Only: Are you pregnant? Yes / No Are you on Birth Control? Yes / No