Shoreline Orthopaedics

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Medical History

Patient Name _____ **DOB** _____ **Date**_____

To help us meet your healthcare needs, please fill out both sides of this form completely. This is a confidential record of your medical history and will not be shared without your authorization.

Reason for Today's Visit:_____**Hand Dominance:** □**R** □**L**

ALLERGIES

□ **No Known Allergies**

Metal: □ No □ Yes, type _____ Adhesives: □ No □ Yes, type _____

Please list all other allergies (Drug and Food) you have been diagnosed with and reaction.

Allergic To:	**Reaction:**	**Allergic To:**	**Reaction:**
_____		_____	
_____		_____	

MEDICATIONS

□ **No Current Medications**

Please list all medications you are currently taking, prescribed and over the counter or provide a list.

Current Medication:	**Dosage:**	**How often per day?**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PAST SURGICAL HISTORY

□ **No Past Surgical History**

Please list **all** operations you have experienced and indicate **year** they occurred.

□ Back Surgery_____	□ Hand Surgery _____	□ Knee Surgery _____
□ Bowel/Stomach Surgery _____	□ Heart Surgery _____	□ Neck Surgery _____
□ Cancer Surgery _____	□ Hip Surgery _____	□ Shoulder Surgery _____
□ Fracture/Bones (Surgical) _____	□ Joint Replacement _____	□ Other _____

Please complete page two (other side) of medical history if you have not done so online

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Only complete this side if you have not done so online

PAST MEDICAL HISTORY

□ **No Past Medical History**

Please check any that apply.

□Arthritis/Type_____
□Back Pain
□Blood Disorder
□Bone Fractures
□Cancer/Type_____
□Depression/Anxiety
□Diabetes/Type_____
□Fibromyalgia
□GERD (reflux)
□Heart Attack
□Heart Condition/Disease
□Hepatitis/Liver Disease
□High Blood Pressure
□High Cholesterol
□HIV/AIDS
□Kidney Disease/Renal Insufficiency
□Lung Disease/Asthma
□MRSA Infection
□Osteopenia/Osteoporosis
□Pulmonary Embolism/DVT
□Seizure Disorder
□Sleep Apnea
□Stroke
□Thyroid Disease
□Other _____

FAMILY HEALTH HISTORY

Are you adopted? □Yes □No

Please indicate if any **Blood Relative** has had any of the following:

	Diabetes	High Blood Pressure	Heart Disease	High Cholesterol	Cancer (Type)	Mental Ill-ness	Blood Disorder (Type)	Lung Disease	Kidney Disease
Father									
Mother									
Paternal Grandfather									
Paternal Grandmother									
Maternal Grandfather									
Maternal Grandmother									
Brother(s)									
Sister(s)									
Son(s)									
Daughter(s)									

SOCIAL HISTORY

Do you use tobacco? □Never □Quit/Age____ □Yes—Type and amount per day?_____

Do you use marijuana? □Never □Yes, Medical □Yes, Recreational

Do you use vape products? □Never □Former □Yes—How much?

Do you drink alcohol? □Never □Former □Yes– How Much/Often? _____

Do you use illegal drugs? □Never □Former □Yes

Do you drink caffeine? □Never □Former □Yes– How much? _____

How much do you exercise? □Sedentary □1-2x/month □1-2x/week □3-4x/week □Daily

Marital Status: □Single □Married □Divorced □Widowed □Partner

What is your current occupation? _____

What is your education level? □Less than high school □High school degree □Some college □Associate degree □Bachelor's degree □Master's degree □Doctorate Degree or higher