

**LANSING ORTHOPEDIC, PC  
PATIENT MEDICAL HISTORY**

NAME \_\_\_\_\_

BIRTH DATE \_\_\_\_\_

Description of your complaint. Include a brief history.

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Right \_\_\_\_\_ Left \_\_\_\_\_

**MEDICAL HISTORY:**

Are you currently receiving treatment or have you received treatment in the past for any of the following conditions?

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Anemia                      | <input type="checkbox"/> Arthritis            | <input type="checkbox"/> Asthma                       | <input type="checkbox"/> Birth Defects       |
| <input type="checkbox"/> Bladder Problems            | <input type="checkbox"/> Bleeding or Bruising | <input type="checkbox"/> Cancer                       | <input type="checkbox"/> Diabetes            |
| <input type="checkbox"/> DVT/Blood Clots             | <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Gallbladder Problems         | <input type="checkbox"/> Gout                |
| <input type="checkbox"/> Heart Disease               | <input type="checkbox"/> Hepatitis            | <input type="checkbox"/> HIV/AIDS                     | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> High Cholesterol            | <input type="checkbox"/> Kidney Problems      | <input type="checkbox"/> Intestinal/Bowel Problems    | <input type="checkbox"/> Liver Disease       |
| <input type="checkbox"/> Lung Problems               | <input type="checkbox"/> Osteoporosis         | <input type="checkbox"/> MRSA/Staph Infection         | <input type="checkbox"/> Phlebitis           |
| <input type="checkbox"/> Peripheral Vascular Disease | <input type="checkbox"/> Polio                | <input type="checkbox"/> Psychological Problems       | <input type="checkbox"/> Pulmonary Embolism  |
| <input type="checkbox"/> Rheumatic Fever             | <input type="checkbox"/> Stroke/TIA           | <input type="checkbox"/> Sexually Transmitted Disease | <input type="checkbox"/> Tuberculosis        |
| <input type="checkbox"/> Thyroid Problem             | <input type="checkbox"/> Ulcer                |   |  |
| <input type="checkbox"/> NONE                        |   |   |  |

Are there any other medical problems we should know about?

**SURGICAL HISTORY:** (List all operations and dates)

**LIST ALL ALLERGIES:** (Medication, Latex, Environmental)

**LIST ALL MEDICATIONS:** (List all current medications including supplements, herbs, vitamins, etc.)

**FAMILY HISTORY:**

(Mother, Father, Grandparents, Brothers, or Sisters been treated in the past or currently receiving treatment for any of the following?)

- |                                       |                                    |  |                                  |
|---------------------------------------|------------------------------------|--|----------------------------------|
| <input type="checkbox"/> Alzheimer's  | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer        | <input type="checkbox"/> None    |
| <input type="checkbox"/> Diabetes     | <input type="checkbox"/> Gout      | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Stroke    | <input type="checkbox"/> Sudden Death  |                                  |

**SOCIAL HISTORY:**

- |  |                              |                             |                  |
|--|------------------------------|-----------------------------|------------------|
| Do you use tobacco?                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | How Often? _____ |
| Do you use alcohol?                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | How Often? _____ |
| Do you use Caffeine?                         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | How Often? _____ |
| Have you used recreational Drugs?            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |                  |
| Have you ever been diagnosed with HIV (AIDS) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |                  |

**The above statements are true to the best of my knowledge.**

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date