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?

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

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?)

- ☐ Alzheimer's
- ☐ Diabetes
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Gout
- ☐ Stroke
- ☐ Cancer
- ☐ Heart Disease
- ☐ Sudden Death
- ☐ None
- ☐ Unknown

SOCIAL HISTORY:

Do you use tobacco?	☐ Yes	☐ No	How Often?_____
Do you use alcohol?	☐ Yes	☐ No	How Often?_____
Do you use Caffeine?	☐ Yes	☐ No	How Often?_____
Have you used recreational Drugs?	☐ Yes	☐ No	
Have you ever been diagnosed with HIV (AIDS)	☐ Yes	☐ No	

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

_____ _____

Patient Signature Date