VANDERBILT UNIVERSITY
MEDICAL CENTER

# Vanderbilt Bone & Joint

## PATIENT HISTORY

**Patient Completed Information>Orthopaedics *IC: Patient History***

**MEDICATION HISTORY: Include all prescriptions and over the counter or herbal supplements**

| MEDICATIONS | DOSAGE | FREQUENCY |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**ALLERGIES:**
Are you allergic to any medication?

| MEDICATION | REACTION |
|---|---|
| | |
| | |
| | |

Do you have any Latex allergies? ____________________

Please list all food allergies (e.g., eggs, shellfish): ____________________

Do you have a problem with Steroidal of Non-Steroidal Anti-Inflammatories? ____________________

**PAST MEDICAL HISTORY: Please check if you have/had any of the following:**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Glaucoma | | Hiatal Hernia | | Scarlet Fever | | Addiction |
| | Cataracts | | Macular Degeneration | | Bleeding Tendency | | Bi-Polar Disorder |
| | Epilepsy / Seizures | | Gastro-Esophageal Reflux | | Pneumonia | | Depression |
| | Migraine Headaches | | Pancreatitis | | Rheumatic Fever | | High Cholesterol |
| | Stroke | | Fibromyalgia | | Venereal Disease | | Bladder Infections |
| | Emphysema | | Diabetes | | Polio | | Kidney Disease |
| | Asthma | | Thyroid Disease | | AIDS or HIV+ | | Kidney Stones |
| | Chronic Bronchitis | | Lupus | | Infectious Mono | | Osteoporosis |
| | Heart Disease | | Osteoarthritis | | Hepatitis | | Neck Problems |
| | High Blood Pressure | | Rheumatoid Arthritis | | Lyme Disease | | Broken Bones |
| | Low Blood Pressure | | Gout | | Blood Transfusions | | Back Problems |
| | Ulcer | | Staph Infection | | Anemia | | |
| | Hemorrhoids | | Tuberculosis | | Blood Clots | | |

☐ **History of Blood Clots - Did it go to your lungs?** ____________________

**Do you have problems clotting?** ____________________

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## PATIENT HISTORY

**Patient Completed Information>Orthopaedics *IC: Patient History***

**CANCER HISTORY:**

| AREA | DATE | REMISSION | ONCOLOGIST |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Have you ever had a blood transfusion? _____ YES _____ NO If YES, when? ________________________________

Other Medical History not listed above: ________________________________________________________________

________________________________________________________________________________________________

**SURGICAL HISTORY:** Please list any previous surgeries and dates or select _____ NONE

Date: ____________________________________________________________________________________________

Date: ____________________________________________________________________________________________

Date: ____________________________________________________________________________________________

**HOSPITALIZATIONS:** Please list any previous hospitalizations and dates or select _____ NONE

Date: ____________________________________________________________________________________________

Date: ____________________________________________________________________________________________

Date: ____________________________________________________________________________________________

**SOCIAL HISTORY:**

**Living Situations**
- ☐ With Family
- ☐ With Friends
- ☐ Alone
- ☐ Other

**Marital Status**
- ☐ Single
- ☐ Married
- ☐ Widowed
- ☐ Other

**Controlled Substances**
- ☐ Alcohol / Drinks per day _____
- ☐ Tobacco / Packs per day _____
- ☐ Recreational Drugs

**Exercise History**

Type of Exercise ______________________ Days per week______ Hours per day _______

**FAMILY HISTORY:** Please list any family identified with a major medical condition as those listed above.

| FAMILY MEMBER | AGE | CONDITION OR DISEASE | AGE AT DEATH |
|---|---|---|---|
| Father | | | |
| Mother | | | |
| Sister | | | |
| Brother | | | |
| Grandmother-Paternal | | | |
| Grandmother-Maternal | | | |
| Grandfather-Paternal | | | |
| Grandfather-Maternal | | | |

**Print Name**_______________________________________ **Signature**_______________________________________

**(Relation to Patient)**______________________________ **Date**__________________ **Time**______________________



*MC3583 (11/2015) - back*