**Vanderbilt Bone & Joint**

**PATIENT HISTORY**

Patient Completed Information>Orthopaedics IC: Patient History

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

<table>
<thead>
<tr>
<th>MEDICATIONS</th>
<th>DOSAGE</th>
<th>FREQUENCY</th>
</tr>
</thead>
<tbody>
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</table>

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

<table>
<thead>
<tr>
<th>MEDICATION</th>
<th>REACTION</th>
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Do you have any Latex allergies? ________________________________________________________________

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

Do you have a problem with Steroidal or Non-Steroidal Anti-Inflammatories? _______________________

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

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

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

Do you have problems clotting? ________________________________________________________________
Vanderbilt Bone & Joint

PATIENT HISTORY

Patient Completed Information>Orthopaedics IC: Patient History

CANCER HISTORY:

<table>
<thead>
<tr>
<th>AREA</th>
<th>DATE</th>
<th>REMISSION</th>
<th>ONCOLOGIST</th>
</tr>
</thead>
<tbody>
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</table>

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       Marital Status       Controlled Substances
☐ With Family       ☐ Single               ☐ Alcohol / Drinks per day ______
☐ With Friends       ☐ Married             ☐ Tobacco / Packs per day ______
☐ Alone             ☐ Widowed             ☐ Recreational Drugs
☐ Other             ☐ Other

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.

<table>
<thead>
<tr>
<th>FAMILY MEMBER</th>
<th>AGE</th>
<th>CONDITION OR DISEASE</th>
<th>AGE AT DEATH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
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<td></td>
</tr>
<tr>
<td>Mother</td>
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<tr>
<td>Sister</td>
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<tr>
<td>Brother</td>
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<td></td>
</tr>
<tr>
<td>Grandmother-Paternal</td>
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<td></td>
<td></td>
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<tr>
<td>Grandmother-Maternal</td>
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<tr>
<td>Grandfather-Paternal</td>
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<tr>
<td>Grandfather-Maternal</td>
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</tbody>
</table>

Print Name_______________________________________ Signature_______________________________________

(Relation to Patient)______________________________ Date__________________ Time______________________