Parkcrest Orthopedics, LLC

Medical History, Surgical History, Allergy and Hospitalization Information

This information is needed to process your insurance claim. Please complete entirely.

NAME:_____ **DOB:**_____

Social History

Alcohol:

O No O Rare O Social O Alcoholic O Recovering Alcoholic

Smoking Status:

O Current Smoker O Former Smoker O Non-Smoker

How long has it been since you last smoked?

O 1-3 Months O <1 Month O 3-6 Months O6-12 Months O 1-5 Years

O 5-10 Years O>10 Years

Are you interested in quitting?

O Ready to quit O Thinking about quitting O Not ready to quit

How many cigarettes a day do you smoke?

O 5 or less O 6-10 O 11-20 O 21-30 O 31 or more

How often do you smoke cigarettes?

O Everyday O Some Days

How soon after you wake up do you smoke your first cigarette?

O within 5 minutes O 6-30 minutes O 31-60 minutes O after 60 minutes

Social History:

Work Status:

O Working O Off Work O Light Duty O Retired O Student

Marital Status:

O Married O Single O Widowed O Separated O Divorced O Partnership

Recreational Drug Use:

O No O Yes

Occupation (or most recent)

Family History: *This section applies to blood relatives only.*

Father:
O Bleeding Disorder O Arthritis O Rheumatoid Arthritis O Anesthesia Complications O Hypertension
O Diabetes O Heart Disease O Stroke O Mental Illness O Cancer O Unknown

Mother:
O Bleeding Disorder O Arthritis O Rheumatoid Arthritis O Anesthesia Complications O Hypertension
O Diabetes O Heart Disease O Stroke O Mental Illness O Cancer O Unknown

Children:
O Bleeding Disorder O Arthritis O Rheumatoid Arthritis O Anesthesia Complications O Hypertension
O Diabetes O Heart Disease O Stroke O Mental Illness O Cancer O Unknown

Siblings:
O Bleeding Disorder O Arthritis O Rheumatoid Arthritis O Anesthesia Complications O Hypertension
O Diabetes O Heart Disease O Stroke O Mental Illness O Cancer O Unknown

Past Medical History:

*This section applies to **your** medical history. Please circle all that apply.*
If none, please mark "NO MEDICAL PROBLEMS" at the end of this form.

Osteoarthritis
Asthma
Congestive Heart Failure
Reflux Disease (GERD)
Hiatal Hernia
Gout
Depression
Obesity
Sleep Apnea
Seizures
DVT O Yes O No
Pulmonary Embolism
Hypertension
Pacemaker
Heart Attack
Cardiac Arrhythmia
Hepatitis C
Hepatitis B
HIV Positive
Kidney Stones

Herniated Disc
O Lumbar
O Cervical
Spinal Stenosis
Blood Transfusion
Blood Dycrasias
Anemia, Iron Deficient
Clotting Disorder
Thyroid Problems
Cancer
Neurological Disorder
Recurrent UTI's
Rheumatoid Arthritis
Fibromyalgia
Lupus Erythematosus
CREST
Arthritis, Psoriatic
Ankylosing Spondylitis

Polymyalgia Rheumatica
Lumbar Radiculopathy
TIA
Stroke
Peptic Ulcer Disease
GI Bleed
Gastro Esophageal Reflux Disease
Avascular Osteopenia
Osteoporosis
Peripheral Vascular Disease
Marfan's Syndrome
Parkinson's Disease
Diabetes
Diabetic Neuropathy
Degenerative Disc Disease

Alcohol Abuse
O Yes
O In the past
Alzheimer's disease
Aneurysm
End Stage Renal Disease/Kidney Failure
Hemophilia
Pseudo Gout
Raynaud's Syndrome
MRSA
Staph Infection

NO MEDICAL PROBLEM

Medical Conditions

This section applies to your medical conditions.
Please circle YES or NO on each condition.

Musculoskeletal:

Joint Stiffness – Yes No

Joint Pain – Yes No

Joint Swelling – Yes No

Joint Redness – Yes No

Lower Back Pain – Yes No

Sciatica – Yes No

Metal Implants – Yes No

Osteoporosis Treatment – Yes No

Constitutional:

Weight Loss – Yes No

Fever – Yes No

Easy Bleeding – Yes No

HEENT:

Ringing in Ears – Yes No

Cardiology:

Chest Pain – Yes No

Palpitations – Yes No

Skipped Beats – Yes No

Gastroenterology:

Dark or bloody stool – Yes No

Heartburn – Yes No

Other

Wheezing- Yes No

Dementia- Yes No

Renal Failure (acute)- Yes No

Renal Failure (chronic)- Yes No

Renal Insufficiency- Yes No

Endocrinology:

Excessive Thirst – Yes No

Excessive Urination – Yes No

Diabetes – Yes No

Neurology:

Headache – Yes No

Gait Difficulties – Yes No

Peripheral Neuropathy – Yes No

Respiratory:

Shortness of Breath – Yes No

Wheezing – Yes No

Chest Congestion – Yes No

Hematology/Lymph:

Night Sweats – Yes No

Fatigue – Yes No

Urology:

Recurrent UTI – Yes No

Burning with Urination – Yes No

Female Reproductive:

Post-Menopausal – Yes No

Metal Allergy

O Nickel

O Steel

O Chromium

O Titanium

O No Metal Sensitivity

SEE REVERSE SIDE→

Surgical History, Hospitalization and Allergies Information

Please list your surgical history below. Write "none" if you have not had any surgery.

Surgery:	Date:

Please list any hospitalization that is not included in above in surgical history. Write " None" if you have never been hospitalized.

Hospital/Reason:	Date:

Please list allergy information and reaction. Write "None" if no known allergies.

Allergic to (Drug/Non-Drug)	Allergic Reaction:

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