



OSMC Physician: _____

Appointment Date: _____

MEDICAL HISTORY & ORTHOPEDIC SCREEN

Date: _____

Legal Name: _____ Date of Birth: _____

Height: _____ Weight: _____

Medication History: Please list the name of all medicines (include vitamins, over the counter medications and birth control) which you are currently taking. **I am currently not taking any medication.**

<u>Drug/Medicine</u>	<u>Drug/Medicine</u>	<u>Drug/Medicine</u>	<u>Drug/Medicine</u>

Allergies: Please include all drug and anesthetic allergies. **I have no known drug allergies.**

<u>Drug/Other</u>	<u>Reaction</u>	<u>Drug/Other</u>	<u>Reaction</u>

Orthopedic Surgeries: Please include all orthopedic surgeries you have ever had in your lifetime.

<u>Date</u>	<u>Surgery/Procedure</u>	<u>Location/Physician</u>

Interventional Pain Procedures: (Epidurals for pain, Radiofrequency, Neuro Stimulators, Implantable Pain Pump, etc.)

<u>Date</u>	<u>Surgery/Procedure</u>	<u>Location/Physician</u>

Other Hospital Admissions/Procedures: Please include other surgeries or hospitalizations you have ever had in your lifetime.

<u>Date/Age</u>	<u>Surgery/Procedure/Hospitalization</u>

Anesthesia: Please check any of the following conditions you have had or now have:

- Previous anesthesia reaction. Please indicate the type of reaction you had: _____
- A family member has had anesthesia reaction. Please indicate type of reaction: _____
- I wear dentures

Latex Allergy: I have had or now have repeated reactions to latex. Yes No

Please indicate what caused your reaction: _____

Type of reaction: _____

Do you handle other rubber items without reaction? Yes No _____Have you ever had a blood test for latex allergy? Yes No Date: _____ Results: _____

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