Chart # _____

Klamath Orthopedic and Sports Medicine Clinic
MEDICAL HISTORY
New patient or yearly update

Name: _____ DOB: _____ Date: _____

Social history:

Do you now or have you ever used tobacco? NO YES (please complete below)
Type of tobacco (cigarettes, chew, etc.) _____
Packs/cans per day: _____
How long have you used tobacco: _____
Quit: _____ years ago.

Do you drink alcohol? NO YES (please complete below)
Type of alcohol (beer, wine, hard, etc.) _____
How often? _____

Do you use recreational drugs? NO YES (please complete below)
Type of drug (marijuana, cocaine, heroin,etc.) _____
How often? _____

Medications

List medications you are currently taking including vitamins and medical marijuana:

Medication name	Strength	Dosage	Reason

Allergies

Drug allergies (hives, rashes, vomiting or unable to breathe): Which medications can you NOT take?

Medication	Reaction	Medication	Reaction

Name _____ Date _____

Past medical history

Please check the appropriate box if you, or anyone in your family, have had any of these medical problems. If you mark yes for the family member, please write which family member next to the medical problem. Example: mother, father, grandmother, etc.

You	Family/**Who**	You	Family/**Who**	You	Family/**Who**
☐	☐ AIDS/HIV _____	☐	☐ Drug Abuse _____	☐	☐ Parkinson's _____
☐	☐ Alcoholism _____	☐	☐ Blood Clots _____	☐	☐ Ulcers _____
☐	☐ Alzheimer's _____	☐	☐ Fibromyalgia _____	☐	☐ Peripheral Vascular Disease _
☐	☐ Anemia _____	☐	☐ Gallbladder _____	☐	☐ Renal Disease _____
☐	☐ Angina _____	☐	☐ Reflux (GERD) _____	☐	☐ Rheumatoid Arthritis __
☐	☐ Arthritis _____	☐	☐ Gout _____	☐	☐ Scoliosis _____
☐	☐ Asthma _____	☐	☐ Hepatitis _____	☐	☐ Seizures _____
☐	☐ Atrial Fibrillation _____	☐	☐ High Cholesterol ____	☐	☐ Sleep Apnea _____
☐	☐ High Blood Pressure _____	☐	☐ Lupus _____	☐	☐ Keloid Scars _____
☐	☐ Cancer _____	☐	☐ Kidney Disease _____	☐	☐ Spinal Stenosis _____
☐	☐ Stroke _____	☐	☐ Liver Disease _____	☐	☐ MRSA _____
☐	☐ Depression _____	☐	☐ Lyme Disease _____	☐	☐ Thyroid Disease_____
☐	☐ COPD _____	☐	☐ Migraines _____	☐	☐ Heart Valve Disease __
☐	☐ Coronary Artery Disease ____	☐	☐ Multiple Sclerosis ____	☐	☐ Neuropathy_____
☐	☐ Crohn's Disease _____	☐	☐ Heart Attack _____	☐	☐ Obesity _____
☐	☐ Degenerative Joint Disease __	☐	☐ Osteoporosis	☐	☐ Chronic Pain Syndrome
☐	☐ Osteoarthritis_____	☐	☐ Malignant Hyperthermia _____		
☐	☐ Congestive Heart Failure ____	☐	☐ Diabetes ☐ Type I ☐ Type II _____		
☐	☐ Other _____				
☐	☐ Chronic Neck Pain _____	☐	☐ Chronic Back Pain _____		

Past surgical history

Please indicate if you have had any of the following surgeries

	Year		Year
☐ Heart Bypass(CABG)	_____	☐ Hip Replacement	_____
☐ Pacemaker	_____	☐ Hip Surgery	_____
☐ Heart Valve	_____	☐ Knee Replacement	_____
☐ Heart Stent	_____	☐ Knee Arthroscopy	_____
☐ Cancer Surgery	_____	☐ Knee Surgery	_____
☐ Prostate Surgery	_____	☐ Shoulder Replacement	_____
☐ Spine Surgery	_____	☐ Shoulder Arthroscopy	_____
☐ Other Surgery	_____	☐ Shoulder Surgery	_____