Mission Peak ORTHOPAEDICS

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Orthopaedic Surgery ■ Arthroscopy & Sports Medicine ■ Shoulder & Elbow Surgery ■ Joint Replacement
Podiatry: Foot & Ankle Surgery ■ Physical Medicine & Rehabilitation ■ Interventional Spine Care

Medical History and Information

Pharmacy Name, Street and city_____

Do you consent for Mission Peak Orthopaedic to e-subscribe your prescriptions to your pharmacy? ☐ YES ☐ NO

Height_____ Weight_____ Left or Right Handed: L / R

Allergies to medications? NO __ If Yes, ☐Penicillin ☐ Sulfa ☐ Novocain ☐Codeine ☐Other_____

What Happens _____

Do you have allergies to foods/other(tape, dye)? NO/ If Yes please describe _____

Do you have or have you had any of the following, please circle or write in specific conditions

	Yes	No		Yes	No		Yes	No
Heart Disease	☐	☐	Shortness of breath	☐	☐	Diabetes	☐	☐
Heart attack/MI	☐	☐	COPD/Emphysema	☐	☐	Renal failure/insufficiency	☐	☐
Pacemaker/AICD	☐	☐	Asthma	☐	☐	Kidney Stones	☐	☐
Chest pain	☐	☐	Sleep Apnea	☐	☐	Bladder problems	☐	☐
Irregular Heart Beat	☐	☐	Tuberculosis/TB	☐	☐	Prostate problems	☐	☐
Valve problem or murmur	☐	☐	Cancer	☐	☐	Thyroid problems	☐	☐
High Blood pressure	☐	☐	Seizure	☐	☐	Easy bruising or bleeding	☐	☐
Stroke	☐	☐	Arthritis	☐	☐	Low platelet count	☐	☐
High Cholesterol	☐	☐	Osteoarthritis, rheumatoid, psoriatic			Blood Clots	☐	☐
Stomach ulcer or Reflux	☐	☐	Back problems	☐	☐	Pulmonary Embolism	☐	☐
Constipation	☐	☐	Autoimmune diseases	☐	☐	Chronic Pain	☐	☐
Diarrhea	☐	☐	Lupus, Reynaud's			Mental Health History	☐	☐
Chron's Disease	☐	☐	Muscular Dystrophy	☐	☐	HIV or AIDS	☐	☐
Ulcerative Colitis	☐	☐	Multiple Sclerosis	☐	☐	Skin Disorders	☐	☐
Diverticulosis	☐	☐	Myasthenia Gravis	☐	☐	Fevers/Chills	☐	☐
Hepatitis	☐	☐	Numbness hands or feet	☐	☐	Recent Weight loss/gain	☐	☐
Jaundice	☐	☐	Dizziness	☐	☐	Current Sore Throat	☐	☐
			Weakness	☐	☐	Recent changes in vision	☐	☐

Answer the following questions as the apply to you: Yes No

Recent illness, cold, cough or fever within the 2 weeks.....☐ ☐

Is there a possibility you are pregnant? ..... .☐ ☐

Last menstrual period_____

Do you have a history of smoking? .....☐ ☐

Packs/day____ #of years____ Date Quit_____

Do you drink alcoholic beverages? .....☐ ☐

How often_____ How much_____

Do you have a history of substance abuse or addiction?.....☐ ☐

Have taken oral or injectable steroids? .....☐ ☐

Are you involved in litigation for this injury? ..... ☐ ☐

If the patient is a child
Please answer the following:

Yes No

Child was born premature .....☐ ☐

Birth defects or developmental delays..... ☐ ☐

History of frequent fractures .....☐ ☐

Immunization problems or delays
in immunization schedule .....☐ ☐

Health Conditions of immediate family members:

.....

Surgeries or Hospitalizations: None If YES please list:	Current Medications: None If YES please list Name and Dosages

Please use reverse side if more room is needed

Patient (or Guardian) Signature_____ **Date**____/____/____