

Additional Medical History

Name _____
(First) (MI) (Last)

Age _____ Sex: M F Height _____ Weight _____ lbs.

Marital Status: _____ Married _____ Divorced _____ Widowed _____ Single

CURRENT PROBLEM: _____

HOW LONG HAVE YOU HAD PAIN? _____ CAUSE: _____

HAVE YOU SEEN ANOTHER DOCTOR FOR THIS? _____

ARE YOU TAKING MEDICATIONS FOR THIS PAIN? ___ YES ___ NO
IF YES, PLEASE LIST THIS MEDICATION AND ANY OTHERS YOU ARE CURRENTLY
TAKING _____

PLEASE INDICATE ANY OF THE FOLLOWING WHICH YOU HAVE HAD PERFORMED:
___ X-RAY ___ CT SCAN ___ MRI ___ EMG

___ BLOOD TESTS, PLEASE LIST IF AVAILABLE: _____

HAVE YOU HAD ANY RECENT:
Fever/Chills/Sweats Yes _____ No _____
Pain or swelling in other joints or muscles Yes _____ No _____

OCCUPATION: _____

DO YOU SMOKE? Yes _____ No _____ USE ALCOHOL? Yes _____ No _____

Does anyone in your family have the same or similar problem? Yes ___ No ___
Does anyone in your family have a different Orthopaedic problem? Yes ___ No ___
Are you parents and siblings alive and healthy? Yes ___ No ___

Is there a chance you might be pregnant? Yes ___ No ___ Last menstrual period _____

HAVE YOU EVER HAD PROBLEMS WITH:

Heart problems	Yes ___ No ___	Cancer	Yes ___ No ___
Diabetes or thyroid	Yes ___ No ___	Asthma/breathing	Yes ___ No ___
Stomach or bowels	Yes ___ No ___	Kidney or bladder	Yes ___ No ___
High blood pressure	Yes ___ No ___	Blood clots	Yes ___ No ___
Allergies	Yes ___ No ___	Nerves	Yes ___ No ___
Bleeding	Yes ___ No ___	Ears/nose/throat	Yes ___ No ___
Eyes	Yes ___ No ___		

List all hip or knee surgeries, dates, and the names of your surgeons:

**PLEASE USE THE REMAINDER OF THIS PAGE FOR ANY OTHER INFORMATION
YOU WANT DR. SHINAR TO KNOW.**

**I have reviewed and confirmed all of the information contained on this sheet with the
patient.**

Andrew Shinar, MD MD Date _____