Cascade Orthopedic Surgery Patient History Sheet

◆ **Ronald L. Teed, M.D., PC** ◆

Name: (First) _____ (MI) _____ (Last) _____

Height: _____ **Weight:** _____ Occupation:_____

Was it accident related? YES NO ☐Work ☐ MVA ☐ Other – explain: _____

_____Date symptoms first appeared: _____

List all surgeries that you have had and when they were performed: _____

_____

_____

List any medical problems or chronic illnesses that you have (diabetes, high blood pressure, asthma, etc.) Also complete attached form: _____

_____

List all medications that you are currently taking: _____

_____

List any medications that you are allergic to: _____

_____

List any broken bones that you have had: _____

Have you ever used tobacco? YES NO When? _____ ☐Chew ☐Cigarettes ☐Cigars ☐Vape

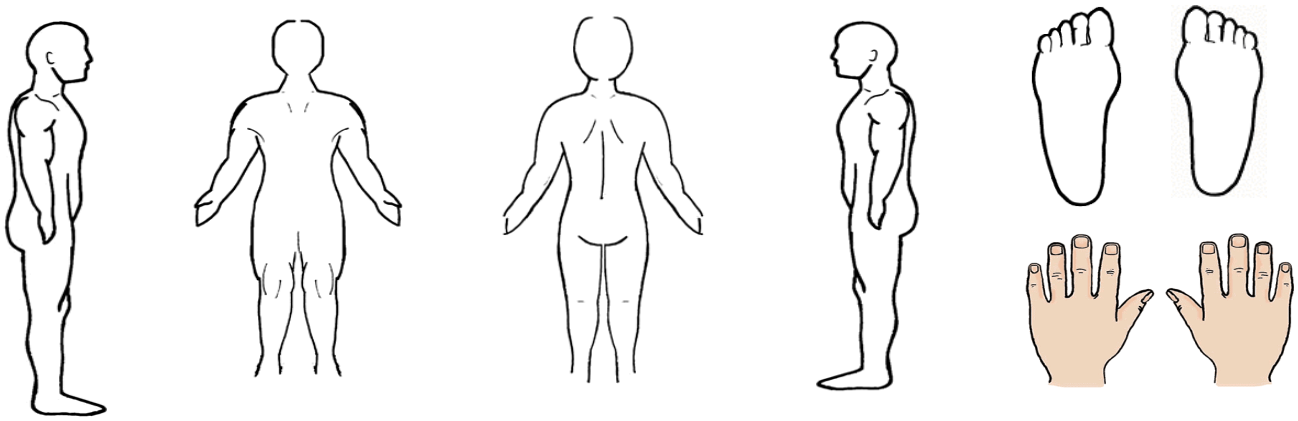
Do you currently use tobacco?: YES NO How frequently: _____

Have you ever used alcohol? YES NO Do you currently use alcohol?: YES NO

How frequently: _____ ☐Beer ☐ Wine ☐ Hard liquor ☐ Malt liquor

Please indicate by circling on the pictures below what area(s) you will be seeing the doctor for today.

Right **Front** **Back** **Left** **Left** **Right**



Please give a brief description why you came to see the doctor today: (If accident, please explain **how** / **what** happened.)_____

EXAM DATE: _____

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*****NOTE: If you are taking medication for a medical condition, then it is a current health issue*****

Please check the box that best applies to each health issue below. Please also list any medication you are taking for that issue.

Asthma	☐ Current	☐ Past	☐ Never	Medication, if any: _____
Emphysema	☐ Current	☐ Past	☐ Never	Medication, if any: _____
COPD	☐ Current	☐ Past	☐ Never	Medication, if any: _____
Sleep apnea	☐ Current	☐ Past	☐ Never	Medication, if any: _____
Tuberculosis (TB)	☐ Current	☐ Past	☐ Never	Medication, if any: _____
Stroke	☐ Current	☐ Past	☐ Never	Medication, if any: _____
Heart Attack	☐ Current	☐ Past	☐ Never	Medication, if any: _____
Bypass / Stent	☐ Current	☐ Past	☐ Never	Medication, if any: _____
High blood pressure	☐ Current	☐ Past	☐ Never	Medication, if any: _____
High cholesterol	☐ Current	☐ Past	☐ Never	Medication, if any: _____
Blood clots	☐ Current	☐ Past	☐ Never	Medication, if any: _____
Diabetes __ 1 __ 2	☐ Current	☐ Past	☐ Never	Medication, if any: _____
Kidney Dialysis	☐ Current	☐ Past	☐ Never	Medication, if any: _____
Hepatitis _ A _ B _ C	☐ Current	☐ Past	☐ Never	Medication, if any: _____
Liver disorder	☐ Current	☐ Past	☐ Never	Medication, if any: _____
Ulcers	☐ Current	☐ Past	☐ Never	Medication, if any: _____
Hiatal hernia	☐ Current	☐ Past	☐ Never	Medication, if any: _____
Heartburn/reflux	☐ Current	☐ Past	☐ Never	Medication, if any: _____
Seizures	☐ Current	☐ Past	☐ Never	Medication, if any: _____
Thyroid _ low _ high	☐ Current	☐ Past	☐ Never	Medication, if any: _____
Anxiety / Depression	☐ Current	☐ Past	☐ Never	Medication, if any: _____
Benign Prostatic Hypertrophy	☐ Current	☐ Past	☐ Never	Medication, if any: _____
Joint replacement	☐ Current	☐ Past	☐ Never	Which joint(s): _____
Cancer / tumors	☐ Current	☐ Past	☐ Never	What kind?: _____
MRSA	☐ Current	☐ Past	☐ Never	Medication, if any: _____

Other: _____

List any medical specialist doctors you are currently treating with for any of the above health issues: _____

_____

PATIENT NAME: _____ **DATE:** _____