MEDICAL HISTORY

MILL VALLEY ORTHOPEDIC CLINIC

Please Print Clearly **Today's Date:** ______________

PATIENT INFORMATION

Name: Age: Date of Birth:

Marital Status: Sex : M ☐ F ☐

Children & age (s): Date of last tetanus:

Reason for visit: Date of last period:

Date of menopause:

LIFESTYLE

Occupation and how many years? Do you consume alcohol? Y / N

How much?

Sports/exercise or other activities you engage in regularly: Do you Smoke? Y/N

Duration & times per week: How much?

PAST SURGERIES

Surgery:	**Date:**	**Surgeon:**

MEDICAL HISTORY

Diagnosis:	**Date of onset:**	**Treating Physician:**

Medications you are on: (List dosages and frequency.)

Allergies to Medications: (What type of reaction did you have?)

DISEASES THAT RUN IN YOUR FAMILY

Are your parents & siblings still alive, and if not, age & cause of death? Other chronic diseases?