

Cascade Orthopedic Surgery Patient History Sheet

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

Date symptoms first appeared: _____ Was it accident related? YES NO

Occupation: _____

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: _____

List any diseases or health problems that run in your family: _____

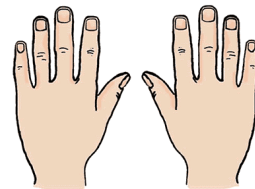
Have you ever used tobacco? YES NO When? _____ Chew / Cigarettes / Cigars

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

Do you use alcohol?: YES NO How frequently: _____

Are you Right or Left handed?: LEFT RIGHT Height: _____ Weight: _____

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



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

Exam Date: _____