Joint Replacement Institute
ST. VINCENT MEDICAL CENTER

PATIENT MEDICAL HISTORY

NAME: ____ **DATE:** ___________________

1.The following is a list of common health problems. Please circle yes or no in the columns as appropriate.

	Do you have the Problem?	Did you receive treatment for it?	Does it limit your activities?
Heart Disease	Yes No	Yes No	Yes No
High Blood Pressure	Yes No	Yes No	Yes No
Lung Disease	Yes No	Yes No	Yes No
Diabetes	Yes No	Yes No	Yes No
Ulcer or Stomach Disease	Yes No	Yes No	Yes No
Kidney Disease	Yes No	Yes No	Yes No
Liver Disease	Yes No	Yes No	Yes No
Anemia or other Blood Disease	Yes No	Yes No	Yes No
Cancer	Yes No	Yes No	Yes No
Depression/Emotional Problems	Yes No	Yes No	Yes No
Osteoarthritis, Degenerative Arthritis	Yes No	Yes No	Yes No
Back Pain	Yes No	Yes No	Yes No
Rheumatoid Arthritis	Yes No	Yes No	Yes No
Glaucoma	Yes No	Yes No	Yes No
Rheumatic Fever	Yes No	Yes No	Yes No
Sinusitis	Yes No	Yes No	Yes No
Urinary Tract Infection	Yes No	Yes No	Yes No
Other Medical Problems (please specify):	Yes No	Yes No	Yes No

2. Menstrual: **Yes** **No** Brief explanation of any problems: ________________________
Pregnancies: # _________ ____
Births: # ___________ ____

3. Have you been hospitalized for any reason, including previous surgeries? If yes, please explain:

Type Hospital/Location Date

A. ____
B. ____
C. ____
D. ____
E. ____
F. ____

4. Were there complications? If yes, please indicate below:

	Yes		**Yes**
Infection	☐	Thrombophlebits	☐
Bleeding	☐	Pulmonary Embolus	☐

Other, Explain:
____
____

5. Allergies

A. Are you allergic to:

	Yes	**No**
Penicillin	☐	☐
Other Antibiotics	☐	☐
Local Anesthetics	☐	☐
Iodine	☐	☐
Aspirin	☐	☐

B. Foods, Please List:
____
____

C. Others, Please List:
____
____

(I:FORMS/PATIENTMEDICALHISTORY.TPS)

6. BLEEDING TENDENCIES

A. Do you bruise easily?________________________ B: Do you bleed excessively if cut? ___________________________
C. Have you previously received a blood transfusion? If yes, please list any and all complications: _______________________
____
D. Have you had any problems with healing after surgery, cuts or abrasions? If yes, please list: __________________________
____

7. Please note details of any serious injuries: ____
____

8. Have you taken any or are you currently taking any of the following medications:

	In Past	Currently Taking	Type	Frequency
Cortisone or Steroid	☐	☐	____________	____________
Birth Control Pills	☐	☐	____________	____________
Premarin	☐	☐	____________	____________
Blood Pressure Pills	☐	☐	____________	____________
Digoxin or Heart Pills	☐	☐	____________	____________
Asprin, Bufferin, etc.	☐	☐	____________	____________
Darvon	☐	☐	____________	____________
Other Pain Medications	☐	☐	____________	____________
Anticoagulants	☐	☐	____________	____________
Eyedrops	☐	☐	____________	____________
Inderol	☐	☐	____________	____________

Other? Please list: ____

FAMILY HISTORY		
1. RECURRING MEDICAL PROBLEMS:	MOTHER Age__________ Health Status _________ Age at Death _________ Cause: ______________	FATHER Age__________ Health Status _________ Age at Death _________ Cause: ______________
2. ORTHOPAEDIC PROBLEMS IN FAMILY:		
3. DIABETES	MATERNAL GRANDMOTHER Age__________ Health Status _________ Age at Death _________ Cause: ______________	PATERNAL GRANDMOTHER Age__________ Health Status _________ Age at Death _________ Cause: ______________
4. CANCER:		
5.. INFECTIOUS DISEASE:	MATERNAL GRANDFATHER Age__________ Health Status _________ Age at Death _________ Cause: ______________	PATERNAL GRANDFATHER Age__________ Health Status _________ Age at Death _________ Cause: ______________
6. OTHER:		

Do Not Write Below This Line – To Be Completed by Physician

PRESENT ILLNESS:____
____
OTHER SERIOUS INJURIES/ILLNESSES:____
____
MEDICAL-LEGAL COMPENSATION ISSUES:____
____