LAFAYETTE Orthopaedic Clinic
A UNITY HEALTHCARE PARTNER

Patient Name: _____ Date: _____

Date of Birth: _____

Family Doctor/Primary Care Physician: _____ Physician Referring You: _____

Past Medical History

	Yes	No	
1. Have you ever had surgery?	☐	☐	Reason: _____
2. Have you ever been hospitalized for a medical condition other than surgery (please include pregnancies)	☐	☐	Reason: _____
3. Do you take any medications on a regular basis? (Please include aspirin, Tylenol, or any other over-the-counter medications. Women, please include contraceptives.)	☐	☐	Please List: _____
4. Do you have any allergies?	☐	☐	Please List: _____
5. Are you currently employed?	☐	☐	Occupation: _____

Note: If you do not know the name of your medications, please indicate why you are taking it.

Social History

	Yes	No	
6. Do you use tobacco products?	☐	☐	How often/amount: _____
7. Have you ever used tobacco?	☐	☐	If yes, when did you stop? _____
8. Do you consume alcohol?	☐	☐	If so, how much? _____
9. Do you live alone?	☐	☐	
10. Is there a chance you could be pregnant?	☐	☐	

Review of Systems

Have you ever had any of the following?

	Yes	No		Yes	No		Yes	No
Lung problems	☐	☐	Joint aches	☐	☐	Bladder/Urinary problems	☐	☐
High Blood Pressure	☐	☐	Depression	☐	☐	Stomach/Bowel problems	☐	☐
Kidney problems	☐	☐	Chest pain	☐	☐	Blood clots	☐	☐
Thyroid problem	☐	☐	Diabetes	☐	☐	Fracture/Broken Bone	☐	☐
Bleeding disorder	☐	☐	Gout	☐	☐	Other: _____		
						Where: _____		

Family History

Do you have a family history of any of the following?

	Yes	No		Yes	No		Yes	No
Heart Disease	☐	☐	Cancer	☐	☐	Bleeding Tendencies	☐	☐
Arthritis	☐	☐	Diabetes	☐	☐	Other: _____		

Additional Comments: _____

_____

_____

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____