Name: _____ Date: _____

William F. Sima, M.D., Inc.

Orthopedic Surgery, Sports Medicine and Joint Replacement

MEDICAL HISTORY

Previous Tests and Treatments

☐ Circle here if none apply

☐ Physical Therapy	☐ Made it worse	☐ Made it better	☐ No effect
☐ Anti-inflammatories	☐ Made it worse	☐ Made it better	☐ No effect
☐ Narcotic medication	☐ Made it worse	☐ Made it better	☐ No effect
☐ Chiropractic/Manipulation	☐ Made it worse	☐ Made it better	☐ No effect
☐ Epidural steroid injection	☐ Made it worse	☐ Made it better	☐ No effect
☐ Steroid injection	☐ Made it worse	☐ Made it better	☐ No effect

☐ X-rays ☐ CT ☐ MRI

Please describe your current problem_____

_____

_____

Current Medication(s):

☐ Circle here if none Preferred Pharmacy: _____

Name of Medication	Dose	Duration
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any ALLERGIES? ☐ Yes ☐ No

1._____ Reaction: _____

2._____ Reaction: _____

3._____ Reaction: _____

Social History (circle all that apply to you)

Drink alcohol? ☐ Never ☐ Social ☐ Mild ☐ Moderate ☐ Heavy

Employment? ☐ Work in the home ☐ Student ☐ Retired ☐ Employed Full Time ☐ Employed Part Time
Occupation _____

Disabled? ☐ Permanent ☐ Temporary ~ Reason for Disability_____

Exercise? ☐ Never ☐ Rarely ☐ Weekly ☐ Daily What type?_____

Marital Status? ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Live alone ☐ Life Partner

Smoking? ☐ No ☐ Yes __

Quit smoking? ☐ No ☐ Yes When? _____ Previously smoked _____ packs per day for ___ years

Name: _____ Date: _____

Family History

Do any of your grandparents, parents, siblings or children have the following diseases?

		Relationship			Relationship
Anemia	□Yes □No	_____	Hypertension	□Yes □No	_____
Asthma	□Yes □No	_____	Kidney Disease	□Yes □No	_____
Autoimmune disorder	□Yes □No	_____	Liver problems	□Yes □No	_____
Bleeding disorder	□Yes □No	_____	Lung problems	□Yes □No	_____
Cancer type: _____	□Yes □No	_____	Rheumatoid arthritis	□Yes □No	_____
Cardiovascular	□Yes □No	_____	Seizures	□Yes □No	_____
Deep Venous Thrombosis	□Yes □No	_____	Stroke	□Yes □No	_____
Diabetes	□Yes □No	_____	Thyroid disease	□Yes □No	_____

Past Medical History (circle all that apply to you) □ CHECK HERE IF NONE APPLY

Dermatologic: lupus / melanoma / skin cancer

Neurological: epilepsy / seizure disorders / stroke

Renal / Urinary: hematuria / kidney problems / incontinence

Endocrine: diabetes / thyroid disorder

Head and Neck: Dentures / migraines / glaucoma

Genetic Background: congenital heart defect / hemophilia / sickle cell

Childhood Illnesses: polio / asthma

Female Reproductive: cancer / tumors

Male Reproductive: BPH / prostate conditions

Gastrointestinal: Crohn's disease / gastritis / GI bleed / irritable bowel syndrome / ulcer

Respiratory: asthma / bronchitis / emphysema / pulmonary embolism / shortness of breath / tuberculosis / COPD

Musculoskeletal: ankylosing spondylarthritis / arthritis conditions / fibromyalgia / osteoporosis / polio / Rheumatoid arthritis

Cardiovascular: cardiac catheterization / cardiac disease / congestive heart failure / deep vein thrombosis / edema / heart valve conditions / myocardial infarction / stroke / hypertension / Atrial fibrillation

Hematologic/lymphatic: anemia / bleeding tendencies / hemophilia / hepatitis

Psychiatric: alcoholism / depression

All Previous Surgeries □ CHECK HERE IF NO HISTORY OF PRIOR SURGERY

1. Date_____ Type_____ L/R
2. Date_____ Type_____ L/R
3. Date_____ Type_____ L/R
4. Date_____ Type_____ L/R
5. Date_____ Type_____ L/R
6 .Date_____ Type_____ L/R

Did you have any complications with your surgeries or anesthesia? □ No □ Yes

Explain if yes _____

Name: _____ Date: _____

Review of Systems (circle all that apply to you) □ **CHECK HERE IF NONE APPLY**

Allergic/ Immunologic: Seasonal Allergies

Cardiovascular: Elevated blood pressure / Heart attack / Heart palpations / Pacemaker / Atrial fibrillation / Heart valve replacement

Constitutional Symptoms: Chills / Fever / Nausea

Ears, Nose, Mouth, Throat: Difficulty with hearing / Cough / Difficulty with swallowing / Loss of hearing

Endocrine: Dry skin / Unusual fatigue / Weight change / Thyroid disease

Eyes: Eye or vision problems / Glasses / Loss of vision

Gastrointestinal: Blood in stool / Diarrhea / Hemorrhoids / Stomach ulcers / GERD

Genitourinary: Blood in urine / Painful urination / Incontinence

Hematologic/ Lymphatic: Anemia / Bleeding problems / Bruise easily

Integumentary: Non healing wound / Rash

Musculoskeletal: Back pain / Difficulty getting out of a chair

Neurological: Balance problems / Difficulty walking / Headaches / Migraines / Seizures / Stroke

Psychiatric: Depression / Anxiety

Respiratory: Asthma / Chest pain / Shortness of breath / Sleep apnea