LAKESIDE ORTHOPAEDIC CENTER LLC of Manning

MEDICAL HISTORY QUESTIONNAIRE

Date: _____

Patient's Name: _____ Age: _____

Reason for seeing doctor today: _____

Date symptoms began_____

Was this job-related? Yes No Have you had x-rays? Yes No

How did you hear about our office? (Check all that apply)

___ Primary care doctor ___ Newspaper ad ___ Yellow pages ___ Friend

___ Other: _____

Do you have past or current history of any of the following? (Check all that apply)

___ Kidney disease	___ Ulcers or blood in stool	___ Diabetes
___ Dialysis	___ Heart murmur	___ Hepatitis
___ Heart disease	___ HIV/AIDS	___ Cancer
___ Emphysema/COPD	___ Asthma	___ High blood pressure
___ Blood clots	___ Abnormal bleeding	___ Depression
___ Urinary tract infections	___ Unexplained weight loss	___ Unexplained rashes
___ Recent cold/flu	___ Sexually transmitted diseases	

Date of last dental exam: _____ Right or Left handed _____

Current Medications, including dose: _____

_____

_____

_____

Any Drug Allergies? Yes No If yes, please list _____

Date of last tetanus shot: _____

Is there any chance you may be pregnant? _____

List ANY surgical procedures you have had in the past and WHEN:

_____ _____

_____ _____

_____ _____

_____ _____

Do you currently smoke? _____ How many cigarettes per day?_____

Do you dip? _____ Have you ever quit using tobacco? _____

Do you drink alcohol? _____ How much? _____

Occupation: _____

Do you attend church services regularly? Yes No

If so, where? _____

Should you come to require surgery, would you like the doctor to pray with you prior to your anesthesia? _____

_____ _____

Signature of Patient / Guardian Date