

Montana Orthopedics and Sports Medicine:

Past Medical History/ ROS Form and Social Family History Form

NAME _____ ACCOUNT# _____ DATE _____

PmHX/ ROS: Are you currently having or have you had problems with:

- | | | | | | |
|--------------------------|-------|-----------------------------|-------|-------------------------------|-------|
| 1. Asthma | Y / N | 14. Heart Disease/Failure | Y / N | 27. Osteoporosis | Y / N |
| 2. Lungs/Breathing | Y / N | 15. Chest Pain | Y / N | 28. Arthritis | Y / N |
| 3. Blood Clots | Y / N | 16. Digestion | Y / N | 29. Depression | Y / N |
| 4. Blood Transfusions | Y / N | 17. Bowel Movement | Y / N | 30. Substance Abuse | Y / N |
| 5. Circulation | Y / N | 18. Bladder | Y / N | 31. Cancer | Y / N |
| 6. Bleeding Disorder | Y / N | 19. Kidney Disease | Y / N | 32. Unexplained WeightLoss | Y / N |
| 7. Anemia | Y / N | 20. Diabetes | Y / N | 33. Unexplained Fever, chills | Y / N |
| 8. AIDS, HIV | Y / N | 21. Stomach Ulcers | Y / N | 34. Men- Prostate | Y / N |
| 9. Hepatitis | Y / N | 22. Surgical Site Infection | Y / N | 35. Women Pregnant Now | Y / N |
| 10. Auto Immune disorder | Y / N | 23. Skin Rash | Y / N | 36. —planning pregnancy | Y / N |
| 11. Positive TB Test | Y / N | 24. Eyes | Y / N | 37. —menopause | Y / N |
| 12. Thyroid | Y / N | 25. Fainting | Y / N | 38. —removal of ovaries | Y / N |
| 13. High Blood Pressure | Y / N | 26. Seizure | Y / N | 39. Other _____ | |

If you marked YES above please explain:

please write on back if you need more room

Item # _____ explain _____

Item # _____ explain _____

Item # _____ explain _____

Current Medications (include over the counter and herbal) Additional room on back.					
MEDICATION	Dose	Frequency	MEDICATION	Dose	Frequency

- ◆ Do you have sleep apnea? Y / N
- ◆ Do you use a CPAP machine? Y / N
- ◆ Have you or your family members had a reaction to anesthesia? Y / N

◆ Previous Hospital Admits or Surgeries: _____

◆ ALLERGIES (circle) None /Yes list: Penicillin, Local anesthesia, other _____

- ◆ Who is your primary care physician/family physician? _____
- ◆ When was your last tetanus shot? _____

◆ SOCIAL HISTORY : Do you use Caffeine how long / how much? _____

- ◆ Do you use tobacco how long / much? _____ Alcohol how long / much? _____
- ◆ Are you married / single? Do you have children? Y / N ages: _____
- ◆ Patient s Occupation _____ Hobbies _____

◆ PAST FAMILY HISTORY REVIEW (Please list who)

Alcoholism _____	Heart Disease _____	HighBlood Pressure _____
Arthritis _____	Mental Illness _____	Bleeding Disorder _____
Cancer _____	Diabetes _____	Stroke _____

_____ Patient signature	_____ Date	_____ Initial/ Date	_____ Initial / Date	_____ Initial /Date	_____ Initial / Date
_____ Initial / Date	_____ Initial / Date	_____ Initial / Date	_____ Initial/ Date	_____ Initial / Date	_____ Initial / Date