Orthopedic Associates of Lancaster, LTD.

Medicines and Allergies (**PFSH** Form 070417)

Patient Name: _____

Account No:_____ **Date**:_____

Medications / Dosage / Frequency (Present medications including blood thinners, oral steroids, vitamins, herbs and over the counter medications)												
Date												

Allergies & Reaction (please list all food and medicine, allergies and reactions to each)
☐ No Known Allergies
Have you ever been tested positive for MRSA? Y N If yes, date and body site_____ **History of Hepatitis Y N If yes, list type of hepatitis**_____ **HIV or HIV Exposure Y N** **Occupation**_____

I have reviewed and completed all three pages of this form

Patient Signature_____ **(Guardian if under age 18)** **Date**_____

Date												
Doctor												
Tech / PA												
Height												
Weight												
Pulse												
BP												
Respirations												

Orthopedic Associates of Lancaster, LTD.

Past Medical History, Family History and Social History (**PFSH** Form 040804)

Patient Name: _____

Account No:_____ **Date**:_____

Do you have any of these symptoms or have they changed since you last reviewed this sheet?

MUSCULOSKELETAL		
other muscle or joint pain	Y	N
other muscle or joint swelling	Y	N
other loose or dislocating joints	Y	N
CARDIOVASCULAR		
chest pain (angina)	Y	N
shortness of breath with activities	Y	N
shortness of breath while sleeping	Y	N
blackouts	Y	N
fluid retention (edema)	Y	N
palpitations	Y	N
irregular heart beat	Y	N
calf pain	Y	N
painful varicose veins	Y	N
leg ulcers	Y	N
GASTROINTESTINAL		
frequent heartburn or indigestion	Y	N
nausea or vomiting	Y	N
diarrhea	Y	N
constipation	Y	N
frequent abdominal pain	Y	N
CONSTITUTIONAL		
generally feeling poorly or always tired	Y	N
fever	Y	N
unexplained weight loss	Y	N
EYES		
double vision	Y	N
blurred vision	Y	N
poor vision	Y	N
EARS, NOSE, MOUTH, THROAT		
trouble hearing	Y	N
ear drainage	Y	N
nasal allergies	Y	N
frequent nosebleeds	Y	N
mouth sores	Y	N
active tooth decay	Y	N
sore throat	Y	N
difficulty swallowing	Y	N

RESPIRATORY		
shortness of breath	Y	N
require oxygen treatment	Y	N
chronic cough	Y	N
pneumonia	Y	N
pulmonary embolus	Y	N
sleep apnea	Y	N
GENITOURINARY		
burning with urination	Y	N
blood in the urine	Y	N
trouble voiding	Y	N
new urinary tract infection	Y	N
get up at night to void more than once	Y	N
SKIN		
rash or skin lesion	Y	N
NEUROLOGICAL		
frequent headaches or migraines	Y	N
seizures	Y	N
weakness	Y	N
numbness	Y	N
tremor	Y	N
PSYCHIATRIC		
severe anxiety	Y	N
depression	Y	N
hallucinations	Y	N
ENDOCRINE		
frequent thirst	Y	N
feel abnormally cold or hot	Y	N
HEMATOLOGY/LYMPHATIC		
easy bruising	Y	N
frequent infections	Y	N
ALLERGY/IMMUNOLOGY		
hives	Y	N

For Staff Only									
Date									
Doctor									
Tech / PA									

Orthopedic Associates of Lancaster, LTD.

Past Medical History, Family History and Social History (**PFSH** Form 040804)

Patient Name: _____

Account No:_____ **Date**:_____

Hospitalizations - Include both medical and surgical admissions for illnesses, infectious diseases, accidents or operations, include out patient surgical procedures.

Month	Year	Reason	Hospital

Have you ever had a blood transfusion? **Y N** If yes, when? _____ _____

Have you ever had complications with anesthesia? **Y N** If yes, describe _____

High Blood Pressure	Y	N	neuropathy	Y	N
heart attack or heart surgery	Y	N	chronic kidney disease	Y	N
heart arrhythmia, fibrillation, pacemaker	Y	N	psychiatric illness or depression	Y	N
phlebitis or pulmonary embolus	Y	N	diabetes	Y	N
emphysema	Y	N	thyroid disease	Y	N
asthma	Y	N	oral prednisone in the last 2 years	Y	N
peptic ulcer disease	Y	N	fracture	Y	N
hiatal hernia (GERD)	Y	N	osteoporosis	Y	N
any diagnosis of cancer, if yes, what kind?	Y	N	anemia	Y	N
prostate disease	Y	N	Are you married?	Y	N
diagnosis of osteoporosis or osteopenia	Y	N	Do you smoke?	Y	N
rheumatoid arthritis, lupus arthritis, gout, PMR	Y	N	Have you smoked in the past?	Y	N
osteoarthritis or degenerative arthritis	Y	N	Drink 2 or more alcoholic drinks a day?	Y	N
Fibromyalgia	Y	N	use drugs socially ?	Y	N
ruptured disc or pinched nerve	Y	N	Family history of cancer?	Y	N
stroke (CVA)	Y	N	Family history of heart disease?	Y	N
Parkinson's Disease	Y	N	Family history of diabetes?	Y	N

For Staff Only

Date										
Doctor										
Tech / PA										