MEDICAL HISTORY FORM

Dr. Nicholas Smith

PATIENT'S NAME:

Please circle whichever is appropriate:

Angina (chest pain)	YES	NO	HIV/AIDS	YES	NO
Heart Attack	YES	NO	Cancer	YES	NO
High Blood Pressure	YES	NO	Seizures	YES	NO
Diabetes	YES	NO	Thyroid problems	YES	NO
Renal disease (kidney)	YES	NO	DVT (blood clots in legs)	YES	NO
Respiratory illness(lungs)	YES	NO	PE (blood clots in lungs)	YES	NO
Bleeding disorder	YES	NO	Difficulty with anaesthesia	YES	NO
Hepatitis (liver disease)					

List any operations you have had in the past:

Did you suffer any major complications after previous surgery?

List any medications you are currently taking:

Do you have any allergies:

Do you smoke?	YES/NO	No. cigs/day ……..	When did you quit? …….
Do you drink alcohol? YES/NO/RARELY		No. of drinks per day ……...	
Have you ever used intravenous drugs?		YES/NO	

SHOULDER / ELBOW QUESTIONNAIRE

Hand Dominance (please circle)	LEFT/RIGHT/AMPIDEXTROUS
Date your shoulder/elbow problem began:	
Were you injured at work?	YES/NO
In your own words, please describe how your injury occurred:	
Do you currently have any of the problems listed below: If so, please describe:	
Shoulder/elbow stiffness:	
Shoulder/elbow weakness:	
Shoulder/elbow instability:	
Have you had any previous surgery on your shoulder/elbow. Please list procedures:	
Have you had any cortisone injections around your shoulder? If so, how many? …….	