Princeton Orthopaedic Associates
Medical History

Name: _____ Age: _____ Date: _____
Medical Doctor's name _____ Occupation _____
Why are you seeing the doctor today? _____

Do you have any medical problems? Please circle "no" or "yes". Please describe all "yes" answers.		
Diabetes	no yes	for how long?
Arthritis	no yes	
Cancer	no yes	
High Blood Pressure	no yes	
Heart Disease	no yes	
Digestive/GI	no yes	
Skin diseases	no yes	
Eyes	no yes	
Ear, Nose, Throat	no yes	
Lungs/Respiration	no yes	
Blood/Bleeding	no yes	
Numbness/Tingling	no yes	
Allergies	no yes	
Latex Allergy	no yes	
Shellfish Allergy	no yes	

Previous surgeries, hospitalizations or illnesses	Year

What medications do you take? Please list dose and schedule (how many times a day)

What is your height? Feet ____ Inches ____ What is your weight? Pounds ____
Do you smoke? yes no Number of packs per day ____ Number of years ____
Do you drink alcohol? yes no Number of drinks per day ____ per week ____

Family Member	Alive	Deceased	Medical problems or cause of death
Father			
Mother			
Siblings			

Reviewed by _____ MD Date _____