MEDICAL HISTORY FORM

1.) Complete ALL questions and fill in ALL blanks.
2.) Please fax completed form to 908-470-9100.

Name:_____

Today's Date:_____Age:_____Height:_____Weight:_____

Dominant Hand: Right or Left Surgery to: Right or Left Shoulder
Right or Left Knee

REQUESTED TIME FRAME FOR SURGERY:
(please check one):

_____ASAP
_____in the next several weeks
_____in the next several months
_____not sure
_____other:_____(please explain)

It is imperative that you discuss any travel plans with your surgical coordinator prior to scheduling surgery.

Please answer each of the following questions:

Are you on any aspirin or blood thinners?.....	Yes	No
Do you have asthma?.....	Yes	No
Do you have a heart murmur/mitral valve prolapse?.....	Yes	No
Have you ever had a heart attack?.....	Yes	No
Do you have sleep apnea?.....	Yes	No
Have you ever been jaundiced/had hepatitis?.....	Yes	No
Do you have diabetes?.....	Yes	No
Do you have high blood pressure?.....	Yes	No
Do you have weakness/numbness in an arm/leg?.....	Yes	No
Could you be pregnant?.....	Yes	No
Do you have a pacemaker?.....	Yes	No
Do you smoke?.....	Yes	No
(If Yes, Amount per day: _____cigarettes or _____pack(s)		
Do you have any body piercings?.....	Yes	No
(If Yes, piercings must be removed for surgery)		
Do you have any allergies to Latex and/or surgical tape?.....	Yes	No
If Yes please indicate reaction: _____		
Do you have any tattoos in close proximity to surgery site?.....	Yes	No

MEDICAL CONDITIONS (List any medical conditions and the treating physicians)

SURGICAL HISTORY (List all surgical procedures you have undergone as well as the dates)

ALLERGIES: (List any allergies to medication(s) and the reaction) If None, please indicate "None".

PLEASE LIST ALL MEDICATIONS THAT YOU ARE TAKING BELOW:

Name of Medication	Dosage	Ordering Physician	Reason