CORNERSTONE ORTHOPAEDIC
TRAUMA ASSOCIATES

Medical History Questionnaire

Full Name: _____ Date of Birth: _____ / _____ / _____

Lifestyle

Exercise: ☐ No ☐ Yes (Type/Frequency: _____)

Illicit Drugs: ☐ No ☐ Yes (Type/Frequency: _____)

Tobacco: ☐ No ☐ Yes (Type/Frequency: _____)

Alcohol: ☐ No ☐ Yes (Type/Frequency: _____)

Caffeine: ☐ No ☐ Yes (Type/Frequency: _____)

Current Medications

If you have a separate list, please provide a copy to your provider and note "SEE LIST".

_____ _____ _____

_____ _____ _____

Allergies

Please list all known allergies, including medications, food, environmental, etc.

_____ _____ _____

_____ _____ _____

Medical History

Check all that apply.

☐ Anxiety	☐ Bipolar	☐ Diabetes	☐ Hyperthyroidism
☐ Arthritis	☐ Cancer	☐ Heart Disease	☐ Hypothyroidism
☐ Asthma	☐ Heart Problems	☐ High Blood Pressure	☐ Seizures
☐ Atrial Fibrillation	☐ Depression	☐ High Cholesterol	☐ Stroke (TIA/"Mini")

Surgical History

Check all that apply.

☐ Appendix	☐ Cesarean Section	☐ Hysterectomy
☐ Hip Replacement	☐ Hernia Repair	☐ Tonsils Removed
☐ Knee Replacement	☐ Heart Bypass	☐ Gallbladder

Additional Information: _____

_____

Family Medical History

Check all that apply and/or fill in the blanks as appropriate OR

☐ Check here if you are adopted and family history is unknown

Mother: ☐ Living ☐ Unknown ☐ Deceased (Age/Cause: _____)

Father: ☐ Living ☐ Unknown ☐ Deceased (Age/Cause: _____)

Condition	Maternal ✓	Paternal ✓	Type/Details
Cancer			
Heart Attack(s)			
Open Heart Surgery			
Thyroid Disease			
Depression			
High Blood Pressure			
Psychiatric Disorders			
Diabetes			
High Cholesterol			
Stroke(s)			

Siblings: # Living _____ # Deceased _____

Please describe sibling(s)'s known medical conditions: _____

_____

Diagnostic/Health Maintenance

Have you previously had a bone density scan (DEXA)? ☐ No ☐ Yes

If **YES**, when & where was your most recent scan? _____

COMPLETED BY:

_____ _____ _____

Signature *Name (Printed)* *Date*