McKinley Orthopedics and Sports Medicine
PATIENT HEALTH HISTORY

Patient's Last Name _____First _____ MI _____

Height _____ Weight _____

Primary Care Physician: _____ Referring Physician: _____

Pharmacy Preference (include location):_____

REASON FOR TODAY'S VISIT: _____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING: (i.e. NSAIDs/arthritis, steroids, pain meds, anti-depressants, antibiotics, blood thinners)

Name/Dosage	Taken for	Name/Dosage	Taken for

ARE YOU ALLERGIC TO ANY MEDICATION? ____ Yes ____ No. If yes, please list below:

Name of Medication	Type of Reaction

Are you allergic to Contrast Dye?
____Yes ____No
If yes, please list type of problems:
_____
_____

SURGERIES AND HOSPITALIZATIONS

List any surgeries you have had (including dates):
_____
_____
_____
_____
_____

_____ _____
Patient Signature Date