

Name: _____

SOCIAL HISTORY:

Do you smoke? ___ Yes ___ No If yes, # packs per day: _____ for _____ years.
Have you ever smoked? ___ Yes ___ No If yes, when did you stop smoking? _____
Do you drink alcohol? ___ Yes ___ No If yes, how much? _____ How often? _____
Do you exercise? ___ Daily ___ Weekly ___ Monthly ___ Rarely ___ Never

If yes, what type of exercise? _____

___ Single ___ Married Employer/Occupation: _____

FAMILY HISTORY: Has anyone in your family ever had:

| Problem | Who? | Problem | Who? |
|---------------------|-------------|-----------------------------------|-------------|
| High Blood Pressure | _____ | Lung Disease | _____ |
| Heart Disease | _____ | Tuberculosis | _____ |
| Cancer | _____ | Bleeding Problems | _____ |
| Diabetes Mellitus | _____ | Problems with anesthesia/surgery? | _____ |

REVIEW OF SYSTEMS: Are you currently having or have you had problems with your:

| | <u>Circle</u> | | <u>Circle</u> | | <u>Circle</u> |
|--------------------|---------------|------------------------|---------------|--------------|---------------|
| Eyes | Yes No | High blood pressure | Yes No | AIDS | Yes No |
| Ears, Nose, Throat | Yes No | Bleeding problems | Yes No | Cancer | Yes No |
| Lungs, Breathing | Yes No | Balance problems | Yes No | Arthritis | Yes No |
| Digestion | Yes No | Numbness/tingling | Yes No | Polio | Yes No |
| Bowel movement | Yes No | Blackout/fainting | Yes No | Tuberculosis | Yes No |
| Bladder problem | Yes No | Psychological problems | Yes No | Epilepsy | Yes No |
| Diabetes | Yes No | | | | |

Please describe any "yes" answers: _____

COMMENTS: _____

RELEASE OF INFORMATION: In the event surgery is scheduled at the Kansas City Orthopaedic Institute, I approve the release of the information on this form to that facility. ___ Yes ___ No

Patient/Guardian Signature: _____ Date: _____

Patient/Guardian Signature: _____ Date: _____

Patient/Guardian Signature: _____ Date: _____

Patient/Guardian Signature: _____ Date: _____