ORTHOPAEDIC RESEARCH CLINIC OF ALASKA
2741 DeBarr Rd., Suite C-214, Anchorage, AK 99508 Phone: 907-644-6055 Fax: 907-644-4885

Last Name: _____ First Name: _____ M.I. ___ Height: _____ Weight: _____ Date of Birth: _____

MEDICAL HISTORY: Have you ever been treated for or had any problems with any of the following?

EYES			**ENDOCRINE**			**GASTROINTESTINAL**		
Wear corrective lenses	yes	no	Thyroid disease	yes	no	Nausea or vomiting	yes	no
Glaucoma	yes	no	Bloody urine	yes	no	Abdominal pain	yes	no
EARS			Diabetes	yes	no	Heartburn	yes	no
Hearing loss	yes	no	Excessive thirst	yes	no	**URINARY**		
Hearing devices	yes	no	**HEMATOLOGICAL/LYMPHATIC**			Excessive urination	yes	no
Ear disease or problems	yes	no	Bleeding/bruising	yes	no	Kidney problems	yes	no
NOSE			Blood clotting	yes	no	Infections	yes	no
Sinus problems	yes	no	Anemia	yes	no	**ORTHOPEDIC**		
CARDIOVASUCLAR			Phlebitis	yes	no	Rheumatism	yes	no
Chest pain	yes	no	Hepatitis: Type _____		no	Arthritis	yes	no
Irregular or fast heartbeat	yes	no	HIV/AIDS	yes	no	Gout	yes	no
Low blood pressure	yes	no	**NEUROLOGIC**			Bone/joint infection	yes	no
High blood pressure	yes	no	Fainting	yes	no	Bone tumor/cyst	yes	no
Heart disease or murmur	yes	no	Seizures-epilepsy	yes	no	Artificial joint	yes	no
RESPIRATORY			Stroke	yes	no	**OTHER PROBLEMS**		
Chronic or frequent cough	yes	no	Paralysis of limbs	yes	no	Recent weight change	yes	no
Shortness of breath	yes	no	**SKIN**			Migraines	yes	no
Asthma or wheezing	yes	no	Skin infections	yes	no	Mental health history	yes	no
Emphysema	yes	no	Skin lesions	yes	no	Sleeping disorder	yes	no
			Recent tattoos	yes	no	Sleep apnea	yes	no

PAST SURGICAL HISTORY: Please list all operations that you have had.
_____ Date: _____
_____ Date: _____
_____ Date: _____

FAMILY HISTORY: Please indicate who in your family has had any history as listed below.
Cancer: _____ Heart disease: _____ Lung problems: _____ Diabetes:_____
Gout: _____ Kidney problems: _____High blood pressure: _____Other: _____

PATIENT SOCIAL HISTORY:
Do you drink alcohol? (choose which option applies to you)
If you quit using alcohol, how long since you quit? _____
Do you use any form of tobacco? _____ What type? _____ How much? _____ How often? _____ How long? _____
If you quit using tobacco, how long since you quit? _____ What is your occupation? _____
Do you use any recreational drugs? _____ What type? _____ How much? _____ How often? _____
How long? _____If you quit using recreational drugs, how long since you quit? _____
Do you live alone? _____ What are your living arrangements? _____

MEDICATIONS: Please list all meds you are taking including over the counter meds and vitamins OR CHECK HERE IF **NONE**
Oral Contraceptives Yes / No Brand_____ Drug: _____ Used for: _____
Drug: _____Used for: _____ Drug: _____ Used for: _____
Drug: _____Used for: _____ Drug: _____ Used for: _____
Drug: _____Used for: _____ Drug: _____ Used for: _____

PREFERRED PHARMACY: _____

ALLERGIES: Please list all food and drug allergies OR CHECK HERE IF **NONE**
_____
_____

Patient or Guardian Name: _____ Date: _____

OFFICE USE ONLY
Comments: _____
REVIEWED BY: _____ Date: _____