

Cascade Orthopedic Surgery Patient History Sheet

◆ Ronald L. Teed, M.D., PC ◆

Name: (First) _____ (MI) _____ (Last) _____

Date symptoms first appeared: _____

Occupation: _____

List all surgeries that you have had and when they were performed:

List any medical problems or chronic illnesses that you have (diabetes, high blood pressure, asthma, etc.) Also complete attached form: _____

List all medications that you are currently taking: _____

List any medications that you are allergic to: _____

List any broken bones that you have had: _____

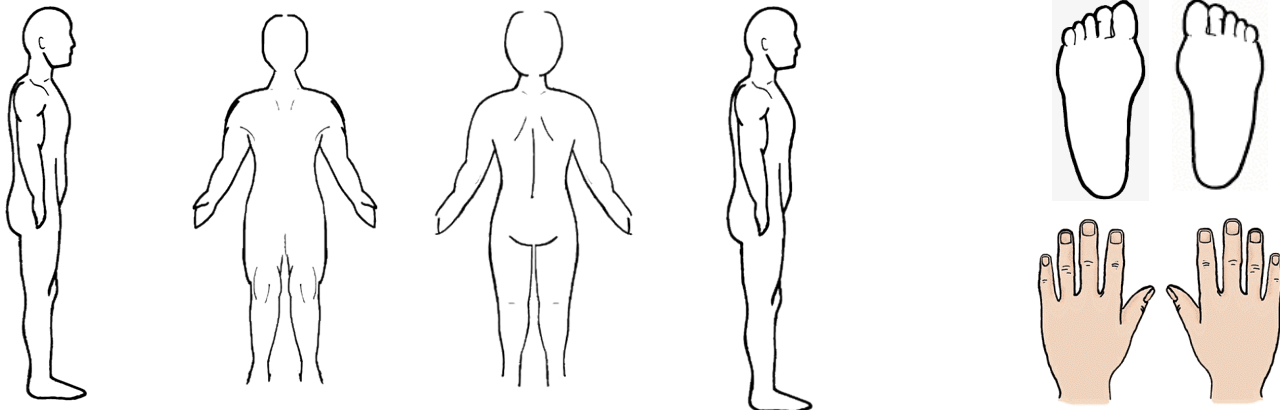
List any diseases or health problems that run in your family: _____

Do you use tobacco?: YES NO Chew /Cigarettes/Cigars How frequently: _____

Do you use alcohol?: YES NO How frequently: _____

Are you Right or Left handed?: LEFT RIGHT Height: _____ Weight: _____

Please indicate by circling on the pictures below what area(s) you will be seeing the doctor for today



Please give a brief description why you came to see the doctor today: (If accident, please explain.)

Date: _____

Updated: _____

Cascade Orthopedic Surgery Patient History Sheet

◆ Ronald L. Teed, M.D., PC ◆

Please indicate if any of the health issues currently apply or you have has a history of any of the following by checking the "Yes" or "No" boxes below. List any medication taken that corresponds to each health issue.

Asthma	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Medication, if any: _____
Bronchitis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Medication, if any: _____
Emphysema	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Medication, if any: _____
Tuberculosis (TB)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Medication, if any: _____

Heart trouble/Issues	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Medication, if any: _____
Heart Attack	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Medication, if any: _____
Palpations	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Medication, if any: _____
Rheumatic fever	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Medication, if any: _____
High blood pressure	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Medication, if any: _____
High cholesterol	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Medication, if any: _____

Blood clots	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Medication, if any: _____
Bleeding problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Medication, if any: _____

Diabetes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Medication, if any: _____
Kidney disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Medication, if any: _____
Hepatitis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Medication, if any: _____
Liver disorder	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Medication, if any: _____

Ulcers	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Medication, if any: _____
Hiatal hernia	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Medication, if any: _____
Persistent heartburn/reflux	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Medication, if any: _____
Stroke	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Medication, if any: _____
Seizures	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Medication, if any: _____
Muscle weakness	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Medication, if any: _____
Muscle disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Medication, if any: _____

Other: _____

List any medical specialist doctors you are currently treating with for any of the above health issues:
