

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/Guardian Signature

Date