Arthritis & Joint Center of Florida
2328 Medico Lane Melbourne, FL 32940
321.956.1501 fax 321.956.1502

PATIENT MEDICAL HISTORY

Height: _____ Weight: _____

Patient Name _____ Today's Date_____

Date of Birth _____

Describe Problem _____

Primary Care Doctor_____ Phone_____

Cardiologist Doctor_____ Phone_____

Pulmonologist Doctor _____Phone_____

Pharmacy_____ Address_____ Phone_____

Previous Surgeries/Year Done:

_____

_____

_____

Current Medications: ☐ NO MEDICATIONS USED

_____

_____

_____

_____

List Allergies to Medications:

_____

_____

Are you currently under pain management? Yes No Provider: _____

Current Living Situation: ___ Alone ___ w/Spouse ____ w/Family ____ w/Friend

Do you use alcohol/drugs? Yes No How often? _____

Tobacco Use (circle one)? Every Day Occasionally Never
Former Smoker (Dates: from _____ to _____)

Vaping w/ Nicotine (circle one) ? Every Day Occasionally Never

******** **Please turnover for additional info-→**

PAST MEDICAL HISTORY : (check all that apply)

____ Anemia	____ Blood Clot	____ Diabetes	____ High Cholesterol
____ Anxiety/Depression	____ Blood Transfusion	____ Gout	____ HIV or AIDS
____ Arthritis	____ Cancer	____ Heart Attack (MI)	____ Hypertension
____ Asthma	____ COPD	____ Heart Problems	____ Kidney Disease
____ Bleeding Disorder	____ Coronary Artery Disease	____ Hepatitis	____ Liver Disease
____ Migraines	____ Orthotics	____ Osteoporosis	____ Peripheral Vascular Disease
____ Pulmonary Embolism	____ Rheumatoid Arthritis	____ Seizures/Epilepsy	____ Sleep Apnea
____ Stroke	____ Thyroid Problems	____ Tuberculosis	____ Ulcers
____ Vascular Stents	____ Atrial Fibrilation	____ Chemotherapy within the last year	
____ Heart Stents	____ Malignant Hyperthermia	____ History of MRSA	
____ Lymphedema	____ Congestive Heart Failure		

Adverse Reaction to Anesthesia other than Nausea and Vomiting:_____

_____

_____

REVIEW OF SYSTEMS (**Please check all that apply)**

CONSTITUTIONAL: ☐FEVER/CHILLS ☐NIGHT SWEATS ☐ WEIGHT GAIN
☐WEIGHT LOSS ☐EXERCISE INTOLERANCE

CARDIOVASCULAR: ☐CHEST PAIN ☐ARM PAIN ON EXERTION ☐CHEST PAIN ON EXERTION
☐SHORTNESS OF BREATH WHEN WALKING ☐SHORTNESS OF BREATH WHEN LYING DOWN
☐PALPITATIONS ☐KNOWN HEART MUMUR ☐LIGHT-HEADED ON STANDING

RESPIRATORY: ☐COUGH ☐WHEEZING ☐SHORTNESS OF BREATH ☐COUGHING UP BLOOD
☐SLEEP APNEA

MUSCULOSKELETAL: ☐MUSCLE ACHES ☐MUSCLE WEAKNESS ☐ARTHRALGIAS/JOINT PAIN ☐BACK PAIN
☐SWELLING IN THE EXTREMITIES

NEUROLOGIC: ☐LOSS OF CONSCIOUSNESS ☐WEAKNESS ☐NUMBNESS ☐SEIZURES ☐DIZZINESS
☐HEADACHES ☐MIGRAINES ☐RESTLESS LEGS