

CINCINNATI BONE & JOINT INSTITUTE

Medical History:

Name: _____

Height _____ Weight _____

Check if you have had any of these **medical problems** in the PAST:

MAJOR ILLNESS	YES	NO	MAJOR ILLNESS	YES	NO
Anemia or Other Blood Disease			Lung Disease		
Anxiety			Muscle Pain or Swelling		
Arthritis/Osteo			Muscular Weakness		
Arthritis/Rheumatoid			Neurological Disease		
Asthma			Neuropathy		
Blood Clots			Numbness or Tingling		
Bronchitis			Paralysis		
Cancer: Type _____			Peripheral Vascular Disease		
Cough			Pneumonia		
Cuts That Don't Stop Bleeding			Psychiatric Illness		
Depression			Pulmonary Embolism		
Diabetes			Rash		
Emphysema			Reflux		
Fever/Chills			Seizures		
Frequent/Easy Bruising			Shortness of Breath		
Glaucoma			Skin Ulcer		
HIV / AIDS			Steroid Use		
Heart Disease			Stroke		
Chest Pain			Swelling of Legs		
Irregular/Rapid Heartbeat			Thyroid Disease		
Hepatitis B			Tuberculosis - TB		
Hepatitis C			Ulcer or Stomach Disease		
High Blood Pressure			Urinary Infections		
Kidney or Bladder Disease			Wound Healing Problems		
Liver Disease			OTHER: _____		
Loss of Vision					

Please list any **operations/surgeries** you have had:

SURGERY/REASON	YEAR	SURGERY/REASON	YEAR
1)		5)	
2)		6)	
3)		7)	
4)		8)	