Tri County
ORTHOPAEDIC CENTER

*Total Joint Replacement, Spine Surgery, General Orthopaedics, Sports Medicine, Arthroscopic Surgery*

## FAMILY MEDICAL HISTORY

MOTHER: ☐ alive and well ☐ active and well but suffers with _____ age _____
☐ Deceased: Cause _____ Age at death _____

FATHER: ☐ alive and well ☐ active and well but suffers with _____ age _____
☐ Deceased: Cause _____ Age at death _____

I have: ☐ living brothers/sisters
☐ Deceased brothers/sisters cause of death(s) _____

Members of my family brothers, sisters, grandparents, aunts and uncles) suffer with the following:

☐ Stroke
☐ Diabetes
☐ Arthritis
☐ Cancer (type) _____
☐ Back problems
☐ I don't know
☐ Other _____
☐ High blood pressure
☐ Heart trouble
☐ Lung disease

**REVIEW OF SYSTEMS** (circle all that apply)

**CONSTITUTIONAL**
☐ Weight loss
☐ Fatigue
☐ Fever

**EYES**
☐ Glasses/Contacts
☐ Pain
☐ Double Vision
☐ Glaucoma
☐ Cataracts
☐ Inflammation

**EARS**
☐ Difficulty hearing
☐ Hearing aid
☐ Ringing/buzzing
☐ Infections

**NOSE/THROAT**
☐ Sinus trouble
☐ Post nasal drip
☐ Nosebleeds
☐ Trouble swallowing
☐ Sore throats

**GASTROINTESTINAL**
☐ Heartburn
☐ Nausea/vomiting
☐ Stomach ulcer
☐ Constipation
☐ Diarrhea
☐ Change in BM's
☐ Bloody stool
☐ Gallbladder trouble
☐ Liver problems

**SKIN**
☐ Rashes/sores
☐ Skin cancers
☐ Itching/burning

**MUSCULOSKELETAL**
☐ Joint pain/swelling
☐ Stiffness
☐ Muscle pain
☐ Back pain

**HEMATOLOGIC**
☐ Anemia
☐ Easy bruising
☐ Bleeding problem
☐ Enlarged glands

**ENDOCRINE**
☐ Loss of hair
☐ Change in nails
☐ Heat/cold intolerance

**RESPIRATORY**
☐ Asthma
☐ Wheezing
☐ Coughing

**CARDIOVASCULAR**
☐ Chest pain
☐ Irregular heartbeat
☐ Low blood pressure
☐ High blood pressure
☐ Shortness of breath
☐ Leg/ankle swelling
☐ Cold fingers/toes
☐ Sweaty fingers/toes

**GENITOURINARY**
☐ Painful urination
☐ Urine leakage
☐ Frequent urination
☐ Nighttime urination
☐ Blood in urine
☐ History of kidney stones
☐ Abnormal discharge
☐ History of sexually transmitted disease

**NEUROLOGICAL**
☐ Fainting
☐ Seizures/Epilepsy
☐ Numbness/Tingling
☐ Weakness/Paralysis
☐ Memory loss
☐ Stroke

**PSYCHIATRIC**
☐ Anxiety
☐ Depression
☐ Drug/Alcohol abuse
☐ OTHER

I certify that I have read the above answers to questions and duly swear and/or affirm that the answers given are true and correct.

Signature _____ Date _____