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Medical History Questionnaire

Please check all health conditions you currently have (or have been diagnosed with in the past):

Pre-Operative Screening:

☐ **NONE OF THE BELOW**

- ☐ Alcohol Abuse or Dependence
- ☐ Anemia
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ CHF
- ☐ Cirrhosis
- ☐ Clotting Disorder
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Deep Vein Thrombosis
- ☐ Diabetes Mellitus
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Other
- ☐ MRSA Infection/Colonization
- ☐ Myocardial Infarction
- ☐ Opioid Dependence
- ☐ Pulmonary Hypertension
- ☐ Sickle Cell Anemia
- ☐ Stroke
- ☐ Substance Abuse
- ☐ TIA

Past Medical History:

☐ **NONE OF THE BELOW**

- ☐ Allergies
- ☐ Anxiety
- ☐ Bleeding Disorder
- ☐ Bursitis
- ☐ Fibromyositis
- ☐ GERD
- ☐ Kyphosis
- ☐ Osteoporosis
- ☐ Seizures
- ☐ Spondylolisthesis
- ☐ Anesthetic Complications
- ☐ Arthritis
- ☐ Blood Disorder
- ☐ Carpal Tunnel
- ☐ Fractures
- ☐ Heart Disease
- ☐ Nerve/Muscle Disease
- ☐ Paget's Disease of Bone
- ☐ Sinus Disorder
- ☐ Thyroid Disease
- ☐ Other
- ☐ Ankylosing Spondylitis
- ☐ Baker's Cyst
- ☐ Bone Cyst
- ☐ Depression
- ☐ Ganglion Cyst
- ☐ Intestinal Disease
- ☐ Osteoarthritis
- ☐ Scoliosis
- ☐ Skin Disease
- ☐ Ulcers

Past Surgical History	Date	**Past Surgical History**	**Date**	**Past Surgical History**	**Date**
☐ Abdomen surgery	_____	☐ Foot fracture surgery	_____	☐ Knee arthroscopy	_____
☐ Ankle fracture surgery	_____	☐ Foot surgery	_____	☐ Knee surgery	_____
☐ Back surgery	_____	☐ Hand surgery	_____	☐ Laminectomy	_____
☐ Carpal Tunnel Release	_____	☐ Heart surgery	_____	☐ Shoulder arthroscopy	_____
☐ Elbow fracture surgery	_____	☐ Hip surgery	_____	☐ Shoulder surgery	_____
☐ Elbow surgery	_____	☐ Humerus fracture surgery	_____	☐ Spinal fusion	_____
☐ Femur fracture surgery	_____	☐ Joint replacement	_____	☐ Wrist fracture surgery	_____

Family History: ☐ Unknown

- ☐ Anesthesia Problems
- ☐ Lupus
- ☐ Diabetes
- ☐ Rheumatoid Arthritis
- ☐ Osteoporosis
- ☐ Clotting Disorders
- ☐ Cancer
- ☐ Osteoarthritis

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Do you smoke? ☐ Yes ☐ No Packs per day: _____ Years of use: _____ Quit Date: _____	Do you use Smokeless Tobacco? ☐ Yes ☐ No Quit Date: _____	**Alcohol Use:** ☐ Yes ☐ No Drinks/Week: _____
History of illegal drug use: ☐ Yes ☐ No Last use date: _____ If yes, what type? _____		

UCSF Patient Assessment

Who do you live with?

☐ Alone ☐ Caregiver ☐ Child(ren) ☐ Family ☐ Friends ☐ Group Home
☐ Homeless ☐ Foster Care ☐ Legal Guardian ☐ Parent ☐ Roommate(s) ☐ Sr Housing
☐ Shelter ☐ Significant Other ☐ Skilled Nursing ☐ Spouse ☐ Other_____

How do you (or your caregiver) learn best (check all that apply)?

☐ Listening ☐ Reading ☐ Demonstration ☐ Pictures/Video ☐ Declined

Do you (or your caregiver) have any barriers to learning (check all that apply)? ☐ No barriers

☐ Reading ☐ Language ☐ Cultural ☐ Visual ☐ Hearing
☐ Physical ☐ Emotional ☐ Cognitive ☐ Spiritual ☐ Financial

Do you (or your caregiver) have any cultural or religious practices or spiritual beliefs that we should be aware of?

☐ Yes ☐ No ☐ Declined

If yes, please describe: _____

Have you fallen since your last visit or within the last year? ☐ Yes ☐ No

If yes, did your fall result in an injury? ☐ Yes ☐ No

Please describe: _____

In the last 12 months, have you been hurt or felt threatened by someone close to you? ☐ Yes ☐ No