ORTHOSURGERY
Ιατρείο Ορθοπαιδικών Παθήσεων
Δρ. Χρήστος Κ. Γιαννακόπουλος
Ορθοπαιδικός Χειρουργός, Διδάκτωρ Πανεπιστημίου Αθηνών

Medical History Form

Πύργος Αθηνών, Κτίριο Γ', 2ος όροφος, Λεωφ. Μεσογείων 2-4, Αθήνα 115 27
Τηλ.: 210 7712792 | Κινητό: 697 20 999 11 | E-mail: cky@orthosurgery.gr

Review of Systems: Do you have or have you had? (Answer yes or no for each)

Fever, night sweats	□Yes □No	Burning with Urination	□Yes □No	Difficulty sleeping	□Yes □No
Eye Pain	□Yes □No	Frequency of urination	□Yes □No	Excessive Thirst	□Yes □No
Sore Throat	□Yes □No	Difficulty Urinating	□Yes □No	Intolerance to heat/cold	□Yes □No
Chest Pain	□Yes □No	Muscle Pain	□Yes □No	Easy bleeding or bruising	□Yes □No

Shortness of Breath	□Yes □No	Skin rashes or sores	□Yes □No
Abdominal Pain	□Yes □No	Headaches or dizziness	□Yes □No
Heart Burn/Reflux	□Yes □No	Depressed	□Yes □No

Past Medical History: Do you have, have you had, or do you take medications for?

Diabetes (if yes do you use an insulin pump? Y N	□Yes □No	Kidney Disease/Nephro tic syndrome	□Yes □No	Paroxysmal nocturnal hemoglobinuria	□Yes □No
High blood pressure	□Yes □No	Seizures	□Yes □No	Inflammatory bowel disease	□Yes □No
Hypercholestero lemia	□Yes □No	Rheumatoid Arthritis	□Yes □No	Cancer (If yes list below?)	□Yes □No
Blood Thinners	□Yes □No	MRSA infection	□Yes □No	Cancer therapy	□Yes □No
Sleep Apnea (if yes, do you use a C-Pap? Y N	□Yes □No	Lower extremity partial or total paralysis	□Yes □No	Leukemia, lymphoma, multiple myeloma	□Yes □No
Asthma	□Yes □No	Varicose veins	□Yes □No	Blood Disorders	□Yes □No
Peptic Ulcer/GERD	□Yes □No	Stroke/Aneurys m	□Yes □No	Thrombophilia	□Yes □No
Liver Disease	□Yes □No	Cardiac Disease/heart attack	□Yes □No	Blood Clots	□Yes □No
Hypo/hyperthyr oidism	□Yes □No	Pregnant within 3 months	□Yes □No	Pulmonary embolism	□Yes □No

Other:

Past Surgical History:

Have you ever had Malignant hyperthermia at the time of surgery? □Yes □No

Procedure	Date	Anesthesia Problems?
□Yes □No		
□Yes □No		
□Yes □No		
□Yes □No		
□Yes □No		
□Yes □No		

Family History: Do any immediate family members have or have had:

Blood Clots or pulmonary embolism	Yes No	Arthritis	Yes No	Sudden death	Yes No
Anesthesia Problems	Yes No	Heart trouble	Yes No	Malignant hyperthermia	Yes No

Social History:

Do you smoke cigarettes, cigars or a pipe?	□Yes □No	If yes, Amount/ frequency years: ___________________________
Do you consume alcohol?	□Yes □No	If yes, #drinks per day/week/mo :___________________________

What is your occupation?
What is your primary sport, hobby or interest?
What is your email address?

Allergies

No Known Drug Allergies

Medication	Reaction

Prescribed Medications

NONE

Name of Medication	Strength	Times per day	Disease Being Treated

Herbal Supplements

NONE

Name of Medication	Strength	Times per day	Disease Being Treated

Over the counter Drugs

NONE

Name of Medication	Strength	Times per day	Disease Being Treated

Past medical History and Review of Systems (Please circle all that apply)

General
Diabetes ____# years
High Blood Pressure
Gout
Fevers
Weight loss
Weight gain
HIV Positive / AIDS
Drug addiction
Alcoholism
Psoriasis
Eyes
Cataracts
Glaucoma
Lens implants
Head and Neck
Deafness
Sinusitis
Hoarseness
Skin / Breast
Breast masses
Breast cancer
Skin lesions / ulcers

Endocrine
Thyroid problems
Anemia
Heart
Chest pain
Palpitations
Irregular heart rhythm
Heart attack ____ year
Heart failure
Mitral valve prolapse
Murmur
Lungs
Asthma
COPD
Wheezing
Emphysema
Cough
Pulmonary embolus

Gastrointestinal
Hepatitis: A, B, C
Cirrhosis
Jaundice
GERD / Reflux
Hiatal hernia
Colon problems
Diarrhea
Constipation
Polyps
Cancer
Women

Pregnancies______
Children______
Menopause

GU System

Urinary hesitancy
Urinary incontinence
Prostate problems
Bladder problems

Musculoskeletal

Osteoporosis
Joint replacement
Bone infection
Rheumatoid arthritis
Previous fractures
Fibromyalgia / Fibrositis
History of Lyme disease
Joint swelling
Joint stiffness

Neuro

Stroke
Numbness / tingling
Seizures
Loss of balance
Loss of memory
Depression
Sleep disturbances
Psychiatric illness