

# Lakeshore Bone and Joint Institute

## Infomedical Sheet

Name: (please print) \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_

Referring MD: \_\_\_\_\_ Medical MD: \_\_\_\_\_

Describe the problem that you are seeing the doctor for today:

Right, Left, or Bilateral: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

*Nurse to fill out	
Ht	Wt
BP	P
RHD	LHD
Grasp	
L =	R =

When did it start/ Date of Injury: \_\_\_\_\_

Does anything make it better? \_\_\_\_\_ Worse? \_\_\_\_\_

Do you smoke? Y or N

If yes, packs per day: \_\_\_\_\_

If you are a former smoker, when did you quit? \_\_\_\_\_

**Allergies:** *If you have any allergies or sensitivity to medications, please list:*

Medication Allergies: \_\_\_\_\_

Latex or rubber allergy: *If yes, please describe reaction:* \_\_\_\_\_

Other Allergies: \_\_\_\_\_

**Past Medical History:** *Please check if you have or have had any of the following*

Arthritis		High Blood Pressure		Breathing Problems		Hyper/Hypothyroidism	
Osteoporosis		Neuropathy		Asthma		Diabetes	
Heart Problems		Blood Clots		High Cholesterol		Cancer	
Heart Attack		Heart Murmur		Depression		Stomach Problems	
Heart Valve Problems		Pacemaker		Kidney Problems		Psychiatric Problems	
Poor Circulation		Phlebitis		Urinary Tract Infect.		Other	

**Perioperative Risk Factors:**

Myocardial Infarction / Heart Attack in the last six (6) months? Yes No

*Check if you are on any of the following medications:*

Prednisone		Aspirin		Blood Pressure		Seizure Medication	
Coumadin/Thinners		Arthritis Medicine		Heart Medicine		Insulin	

