

Lonestar Orthopaedic, Inc.
3219 Clifton Avenue
Suite 300
Cincinnati, Oh 45220

Patient Past Medical History

Name: _____ **Date of Birth:** _____ **HT:** _____ **WT:** _____

Are you claustrophobic: Yes or No

DO YOU NOW HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING: (CIRCLE)

- | | | |
|----------------------------|-------------------------------------|------------------------------|
| AIDS/HIV | DOWN SYNDROME | LEUKEMIA |
| ALCOHOLISM | DRUG ABUSE | LEIDEN 5 FACTOR |
| ALLERGIES, (Environmental) | ECZEMA | LIVER DISEASE |
| ALZHEIMER | FACTOR FIVE | LUNG CANCER |
| ANEMIA | FIBROMYALGIA | LYMPHOMA |
| ANEURYSM | GERD/REFLUX | MUSCULAR DYSTROPHY |
| ANXIETY | GOUT | MRSA |
| ARTHRITIS | HEART DISEASE | MVP, (Mitral Valve Prolapse) |
| ASTHMA | HEART MUMUR | NEUROPATHY |
| BLEEDING PROBLEMS | HYPERTENSION, (High Blood Pressure) | OSTEOARTHRITIS |
| BLOOD CLOT/DVT | HYPERLIPIDEMIA, (High Cholesterol) | OSTEOPOROSIS |
| BREAST CANCER | HYPERTHYROID | PARKINSONS |
| CERVICAL CANCER | HYPOTHYROID | PROSTATE CANCER |
| CEREBRAL PALSY | HEPATITIS: A, B or C | PSORIASIS |
| COLON CANCER | IBS | RHEUMATOID ARTHRITIS |
| COPD | KIDNEY DISEASE | SEIZURE |
| CROHNS DISEASE | KIDNEY TRANSPLANT | ULCERS |

OTHER: _____

PLEASE LIST ANY/ALL PREVIOUS FOOT/ANKLE SURGICAL PROCEDURES: (year and side):

PLEASE LIST ALL CURRENT PRESCRIPTION MEDICATIONS YOUR ARE TAKING AND DOSAGE OF MEDICATION: (if you have a list please attach, we will give it back)

ALLERGIES: ARE YOU ALLERGIC TO ANY MEDICATIONS or SUBSTANCES? YES or NO

IF YES PLEASE LIST: _____

SIGNATURE: _____ **DATE:** _____

If necessary please use other side