Space Coast Orthopaedic Center
220 N. Sykes Creek Pkwy., Suite 200
Merritt Island, Fl 32953

MEDICAL QUESTIONNAIRE

Name: _____ Email: _____ Acct #:_____

Today's Date: _____ Age: _____ DOB: _____

Occupation:_____ If retired previous Occupation: _____

Give a brief description of the reason for today's visit

_____

_____

Please list the following:

Medications you are presently taking	Prescribing Physician	Any Known Allergies
_____	_____	_____
_____	_____	_____
_____	_____	_____

Height: _____ Weight: _____

Do you smoke cigarettes? Yes ___ No___ If yes, list quantity per day _____
Do you consume alcohol? Yes ___ No ___ If yes, list quantity per day _____
Do you live alone? Yes ___ No ___ If yes, who is your support person _____
Are you disabled? Yes ___ No ___ If yes, temporary or permanent _____
Are you pregnant? Yes ___ No ___ If yes, due date is: _____

Do you have or have you had any of the following conditions? Please circle those that apply.

Respiratory Problems
- Asthma
- Chronic Lung problems

Digestive Problems
- Heartburn
- Hiatal hernia
- Stomach ulcers

Endocrine Problems
- Gout
- Diabetes

Central Nervous System
- Epilepsy
- Seizures

Musculoskeletal Problems
- Osteoporosis
- Scoliosis
- Back Injury
- Arthritis

Genito/Urinary Problems
- Prostate/Kidney problem
- Herpes
- Frequent Urinary Tract Infection

Contagious Diseases
- Cough
- Cold (within last 4 wks)
- Hepatitis/Jaundice (yellow skin)
- HIV/AIDS

Cardiovascular Problems
- Heart Attack Chronic
- Angina/chest pain
- Congestive Heart Failure
- Palpitations/arrhythmia
- Heart murmer
- Heart Valve problems
- Prior cardiac surgery
- Prior cardiac catheterization
- High Blood Pressure
- Blood clots or Phlebitis
- Bleeding Problems

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ACCOUNT #: _____

Please list any pertinent medical conditions not mentioned : _____
_____

Have you had any bone fractures? Yes __ No __ If yes, Where: _____
Are you currently seeing a cardiologist? Yes __ No __ If yes, Who?: _____
Have you ever had an abnormal chest x-ray? Yes __ No __ If yes, When: _____
Have you ever had a Stroke? Yes __ No __ If yes, When_____
List any impairments resulting from the stroke:
_____
_____
Are you currently taking Cortisone, Prednisone or Steroid by mouth or injection? _____

Do you have a **FAMILY** history of:

Bleeding ……	Yes___	No ___
Anesthesia Reactions……	Yes ___	No ___
Diabetes……..	Yes ___	No ___
Arthritis……..	Yes ___	No ___
Heart Attack……	Yes ___	No ___
Cancer…….	Yes ___	No ___
Muscular Dystrophy……	Yes ___	No ___
Hypertension…….……..	Yes ___	No ___

Please list all previous surgeries in order of age that they occurred:

Surgery	Date	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If you have previously had surgery did you……..

Have a reaction to the anesthesia? Yes ___ No ___
Have any problems healing? Yes ___ No ___
Have any surgical complications? Yes ___ No ___