ORTHOPAEDIC ASSOCIATES OF CENTRAL TEXAS
Ph. 512-244-0766 • Fax 512-244-1013
www.oactdocs.com

AUSTIN BONE & JOINT CLINIC
Phone 512-477-6341 · Fax 512-477-1148
www.abjortho.com

GAO GREATER AUSTIN ORTHOPAEDICS
Phone 512-401-8400 · Fax 512-441-6388
www.gaortho.com

PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. **Please fill out every item.** It is important for your doctor to know you have carefully reviewed every area of this form. This information will be entered into the computer and you are welcome to a copy of the report if you wish.

Patient's Last Name First MI

Sex: Male ☐ Female ☐ Date of Birth:

Name of Primary Care Physician:

Pharmacy Preference (include location):

REASON FOR TODAY'S VISIT:

Height: Weight: Age:

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

Name of Medication	Dosage	How Often Taken

ARE YOU ALLERGIC TO ANY MEDICATION?

Yes ☐ No ☐ If YES, please list below:

Name of Medication	Type of Reaction

SURGERIES AND HOSPITALIZATIONS

Have you ever had any problems with anesthesia (being numbed or put to sleep)? Yes ☐ No ☐

If YES, please list the type of problems:

List any surgeries you have had (including dates):

Have you ever been hospitalized for non-surgical reasons? Yes ☐ No ☐

If YES, list reasons for hospitalizations

CURRENT OR MOST RECENT OCCUPATION: