JOINT IMPLANT SURGEONS OF FLORIDA

"The Best Surgeons in the Joint"

JOHN B. FENNING, M.D. | EDWARD T. HUMBERT, D.O.
Specializing in Joint Replacement and Arthroscopy of the Knee, Hip and Shoulder

DENNIS O. SAGINI, M.D.
Specializing in Surgery of the Hand, Wrist, Elbow and Upper Extremity

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PATIENT MEDICAL HISTORY

Patient Name: ______________________ Date: __________ Chart# __________

❑ Male ❑ Female Date of Birth: ______________________ Age: __________

Dominant Hand: ❑ Right ❑ Left Height: __________ Weight: __________

Chief Complaint: ______________________ Date of Injury: __________

Primary Care Physician: ______________________ Cardiologist: __________

HEALTH HISTORY

Please check any of the following conditions that apply to you:

❑ Anemia	❑ Aneurysm	❑ Arthritis	❑ Atrial Fibrillation
❑ Blood Clots/Phlebitis	❑ Bone Cancer	❑ Bronchitis/Emphysema	❑ Congestive Heart Disease
❑ Depression	❑ Diabetes	❑ Fibromyalgia	❑ Glaucoma
❑ Gout	❑ Heart Attack	❑ Hepatitis	❑ Herpes Virus/Shingles
❑ HIV/AIDS	❑ Chest Pain	❑ High Cholesterol	❑ Liver Disease
❑ Lung Disease	❑ High Blood Pressure	❑ Rheumatoid Arthritis	❑ Seizures
❑ Stomach Ulcers	❑ Kidney Disease	❑ Thyroid Disease	❑ Tuberculosis
❑ Stroke	❑ Mental Illness		

Any unlisted medical conditions/problems: ______________________

Date of last bone density scan:__________ Recent infection (past 6 months): __________

Ambulation: ❑ Independent ❑ Cane ❑ Walker ❑ Wheel Chair

PAST SURGICAL HISTORY

PROCEDURE	DATE	PROCEDURE	DATE

Have you ever had a complication/reaction to Anesthesia? Personal? ❑ Yes ❑ No Family? ❑ Yes ❑ No

CURRENT MEDICATIONS & DOSAGE: Prescribed and Over-the-Counter

MEDICATION	DOSE	MEDICATION	DOSE

If additional space is needed, please use back of paper.

ALLERGIES

Allergies to medicine? ❑ None

MEDICATION NAME	REACTION	MEDICATION NAME	REACTION

Allergies to: ❑ Latex ❑ Metal ❑ Adhesive Tape ❑ Iodine ❑ Seafood

Reaction to blood transfusion: ❑ Yes ❑ No

FAMILY HISTORY

	FATHER	MOTHER	SIBLINGS		FATHER	MOTHER	SIBLINGS
Alcoholism	❑	❑	❑	Mental Illness	❑	❑	❑
Asthma	❑	❑	❑	Kidney Disease	❑	❑	❑
Bleeding Disorder	❑	❑	❑	Stroke	❑	❑	❑
Cancer	❑	❑	❑	Arthritis	❑	❑	❑
Heart Disease	❑	❑	❑	Thyroid Disease	❑	❑	❑
High Blood Pressure	❑	❑	❑	Other ____________	❑	❑	❑

CAUSE OF DEATH

PARENTS	SIBLINGS

SOCIAL HISTORY

Occupation: ________________________ Employer: ________________________

Currently Working? ❑ Yes ❑ No Last Date Worked? ____________________

❑ Married ❑ Single ❑ Divorced Sports/Hobbies ____________________

Living Arrangement: ❑ Alone ❑ With Family ❑ Assisted Living ❑ Skilled Nursing Facility

Tobacco: ❑ Cigarette packs/day ________years _______ Alcohol: ❑ Never ❑ Occasional ❑ Moderate ❑ Heavy

❑ Pipe ❑ Cigar ❑ Smokeless Tobacco Recreational Drugs: ❑ Yes-Type _____________ ❑ No

REVIEW OF SYMPTOMS

Please check any symptoms you have had ***recently:***

❑ Fever or chills	❑ Chest pain	❑ Persistent cough	❑ Joint stiffness or pain
❑ Weight loss	❑ Heart murmur	❑ Nausea or vomiting	❑ Skin lesions or rashes
❑ Shortness of breath	❑ Heartburn or indigestion	❑ Weakness or paralysis	❑ Change in vision
❑ Seizures	❑ Change in bowel habits	❑ Dizziness or fainting spells	❑ Ringing in ears
❑ Difficulty laying flat	❑ Difficulty or painful urinating	❑ Hair loss	❑ Trouble swallowing
❑ Swollen ankles	❑ Frequent urination	❑ Hay fever/Asthma	❑ Loss of hearing
❑ Palpitations	❑ Easy bruising	❑ Anxiety/Depression	❑ Toothache/Gum trouble

By signing this form, I certify the information provided is accurate and correct to the best of my knowledge.

Signature: ____ Date: ________/________/____________

IF YOU NEED ADDITIONAL SPACE, PLEASE USE THE AREA BELOW: