EDWARD C. SUN, MD
BOARD CERTIFIED ORTHOPAEDIC SURGEON

MEDICAL HISTORY

Patient's Name: _____ Date of Birth: ____/____/____

Present Medications: (name and dose)
Medication allergies:
Previous operations: (when and where)
Previous hospitalizations: (when and where)
Have you ever smoked: Yes No If you quit, when?
Do you drink alcohol None Occasionally Daily

PLEASE CIRCLE YES OR NO TO THE FOLLOWING QUESTIONS:

Have you ever had:

Heart problems	YES NO	Thyroid problems	YES NO	alcohol or drug addiction	YES NO
High blood pressure	YES NO	Kidney problems	YES NO		
Irregular pulse	YES NO	Ulcers	YES NO	Difficulty urinating	YES NO
Chest pain/angina	YES NO	Bleeding problems	YES NO	Difficulty with bowel function	YES NO
respiratory problems	YES NO	Anemia	YES NO		
Asthma	YES NO	Stroke	YES NO	Numbness	YES NO
Diabetes	YES NO	Blood clots	YES NO	Weakness	YES NO
Seizures/epilepsy	YES NO	Cancer/malignancy	YES NO		

EXPLANATION OF ABOVE/OTHER MEDICAL PROBLEMS:

FAMILY HISTORY:

RELATIVE	LIVING	WELL	DECEASED	AGE NOW OR AT TIME OF DEATH	CAUSE OF ILLNESS
Father					
Mother					
Children					

HAS ANY BLOOD RELATIIVE:

	YES	NO	IF YES, INDICATE WHO?
Had early heart disease			
Had cancer?			
had unusual bleeding tendencies?			
Had scoliosis or congenital deformities?			

Patient's Signature: _____ Today's Date: ____/____/____