SRO Santa Rosa Orthopaedics
Expertise. Care. Healing.

Patient History Form

Patient Information

Name: ____ Today's Date: _____/_____/_____

Height: _________ Weight: ________ lbs. D.O.B._____/_____/ ________ Age: ______ Sex: Male ☐ Female ☐

Marital Status: ☐Married ☐ Divorced ☐ Separated ☐Widowed ☐ Single ☐Children How many? _______

Employment /Occupation: ____☐ Student ☐Retired ☐Unemployed

Medications If none, please check here ☐

Please list ALL medications you are taking (include prescription, over-the-counter and/or herbal and nutritional supplements).

Pharmacy: ____
(If more room is needed, use "Comments" at end of form.)

Name: ______________________________Dosage: ___________ Name: ______________________________ Dosage: ___________
Name: ______________________________Dosage: ___________ Name: ______________________________ Dosage: ___________
Name: ______________________________Dosage: ___________ Name: ______________________________ Dosage: ___________
Name: ______________________________Dosage: ___________ Name: ______________________________ Dosage: ___________

Do you take any blood thinners (i.e. Coumadin, Plavix, aspirin, etc.)? q Yes q No If yes, please describe: _________________________
____

Have you had any problems with anesthesia? ☐Yes ☐No If yes, please explain: ____
____

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be hazardous to my health. It is my responsibility to inform the doctor of any changes in my medical status. I also authorize the health care staff of Santa Rosa Orthopaedics to perform the necessary services I may need.

____Date: __________________
Signature of Patient or Parent of Minor:

____Date: __________________
Reviewed by Physician:

Additional Comments: