Tarun Bhargava, M.D.
MIS Anterior Hip Reconstruction, Hip Resurfacing, Total and Partial Knee Reconstruction

Phillip F. Hagan, M.D.
Arthroscopic Knee Surgery, Shoulder Surgery and Sports Medicine

Orthopaedic & Sports Medicine at Cypress

Bradley W. Bruner, M.D.
Arthroscopic Knee Surgery, and Sports Medicine

James Joseph Jr., M.D.
Total Joint Reconstruction of Knees and Hips

9300 E. 29th St. N., Suite 205 | **Wichita, KS 67226** | **Tel:** 316.219.8299 | 888.397.7362 | **Fax:** 316.219.5899

PATIENT HISTORY

PATIENT NAME (LAST)	(FIRST)	(MIDDLE)	☐ MALE ☐ FEMALE	AGE	HEIGHT	WEIGHT

PATIENT MEDICAL HISTORY

Do you have or you ever had any of the following conditions?

Alcohol Consumption.............. Yes ☐ No ☐
How much? ____
Anemia.................................. Yes ☐ No ☐
Anesthesia Problems.............. Yes ☐ No ☐
Arthritis................................. Yes ☐ No ☐
Asthma.................................. Yes ☐ No ☐
Bladder disorder..................... Yes ☐ No ☐
Bleeding disorder................... Yes ☐ No ☐
Bowel disorder....................... Yes ☐ No ☐
Bronchitis............................... Yes ☐ No ☐
Cancer.................................... Yes ☐ No ☐
Where? ____
Type? ____
Convulsions............................ Yes ☐ No ☐
Currently Pregnant?................ Yes ☐ No ☐
or possibly Pregnant?............. Yes ☐ No ☐

CVA/Stroke/TIA........................ Yes ☐ No ☐
Hemorraghic Stroke in last 6 mos.? Yes ☐ No ☐
Depression............................... Yes ☐ No ☐
Diabetes.................................. Yes ☐ No ☐
Insulin Required?........................ Yes ☐ No ☐
Emphysema............................ Yes ☐ No ☐
Use Home Oxygen?.................... Yes ☐ No ☐
Epilepsy.................................. Yes ☐ No ☐
Fainting Spells........................ Yes ☐ No ☐
Glaucoma................................ Yes ☐ No ☐
Had a cold recently?............... Yes ☐ No ☐
Hearing problems................... Yes ☐ No ☐
Hepatitis................................ Yes ☐ No ☐
HIV/AIDS exposure.................. Yes ☐ No ☐

Jaundice.......................... Yes ☐ No ☐
Kidney Problems/Dialysis.. Yes ☐ No ☐
Creatinine Level Greater than 2.... Yes ☐ No ☐
Latex sensitive.................. Yes ☐ No ☐
Malignant Hyperthermia........ Yes ☐ No ☐
Pneumonia........................ Yes ☐ No ☐
Sinusitis............................ Yes ☐ No ☐
Sickle Cell......................... Yes ☐ No ☐
Sleep Apnea...................... Yes ☐ No ☐
CPAP?............................... Yes ☐ No ☐
Smoking............................ Yes ☐ No ☐
How Much? ____
Stomach disorder............. Yes ☐ No ☐
Thyroid problems............. Yes ☐ No ☐
Tremors/Parkinson's.......... Yes ☐ No ☐

Other Medical Conditions: ____

Please list all current medications (including any Herbal medications and/or supplements): ____

Please list any medications that you are allergic to and your reaction to them: ____

Please list all previous surgeries: ____

CARDIOVASCULAR HISTORY

Do you have any heart disease?...................... Yes ☐ No ☐
Do you have any high blood pressure?............ Yes ☐ No ☐
Do you have palpitations?.............................. Yes ☐ No ☐
Do you have fast heartbeats?.......................... Yes ☐ No ☐
Do you have a heart murmur?......................... Yes ☐ No ☐
Do you suffer from chest pain/angina?........... Yes ☐ No ☐
Have you ever had a heart attack?.................. Yes ☐ No ☐
If yes, within the last 6 months............. Yes ☐ No ☐

Do you have Congestive Heart Failure?.................................... Yes ☐ No ☐
If yes, have you been treated in last 3 months?................. Yes ☐ No ☐
Do you suffer from irregular heartbeats?................................. Yes ☐ No ☐
Do you have a cardiac pacemaker or defribrillator?.............. Yes ☐ No ☐
Can you climb a flight of stairs without panting?...................... Yes ☐ No ☐
Metal Heart Valve?... Yes ☐ No ☐
Cardiac Stent?..... Yes ☐ No ☐ When was it placed? ____
Do you become short of breath when you lie down?................ Yes ☐ No ☐

FAMILY MEDICAL HISTORY

Please list any family medical history: (living or deceased) What family member?

Condition	Yes	No	Relation	Living	Deceased
Cancer	☐	☐	Relation: ____	☐	☐
Heart disease	☐	☐	Relation: ____	☐	☐
High blood pressure	☐	☐	Relation: ____	☐	☐
Diabetes	☐	☐	Relation: ____	☐	☐
Depression/Mental disorders	☐	☐	Relation: ____	☐	☐
Problems with Anesthesia	☐	☐	Relation: ____	☐	☐
Other ____			Relation: ____	☐	☐

PATIENT SIGNATURE	DATE	BLOOD PRESSURE	PULSE