



Bret Sokoloff, MD, MBA
Orthopaedic Surgeon

PAST SURGICAL HISTORY

Have you ever had any prior surgeries (from birth to current)? Yes ☐ (please check all surgeries) No ☐

- | | | |
|-------------------------------------------|------------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Heart Stent | <input type="checkbox"/> Shoulder Scope |
| <input type="checkbox"/> Arterial Bypass | <input type="checkbox"/> Heart Bypass | <input type="checkbox"/> Shoulder Cuff Repair |
| <input type="checkbox"/> Back Surgery | <input type="checkbox"/> Hip Replacement | <input type="checkbox"/> Shoulder Replacement |
| <input type="checkbox"/> Bowel Surgery | <input type="checkbox"/> Knee Replacement | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Defibrillator | <input type="checkbox"/> Knee Scope | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Dialysis | <input type="checkbox"/> Neck Surgery | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Fracture Surgery | <input type="checkbox"/> Nerve Surgery/Release | |
| <input type="checkbox"/> Gall Bladder | <input type="checkbox"/> Pacemaker | |

MEDICATIONS

Have you received narcotics/pain medicine from another physician in the past 30 days? ☐ Yes ☐ No

LIST ALL PRESCRIPTIONS, OVER THE COUNTER DRUGS, AND VITAMINS

1. _____ Dosage: _____
2. _____ Dosage: _____
3. _____ Dosage: _____
4. _____ Dosage: _____
5. _____ Dosage: _____
6. _____ Dosage: _____
7. _____ Dosage: _____
8. _____ Dosage: _____

ALLERGIES

Do you have an allergy to LATEX? ☐ Yes ☐ No

Do you have any allergies to food? ☐ Yes ☐ No

1. _____ Reaction: _____
2. _____ Reaction: _____

Do you have any allergies to medicines? ☐ Yes ☐ No

1. _____ Reaction: _____
2. _____ Reaction: _____
3. _____ Reaction: _____