



Confidential Health History

Today's Date: _____

Treating Physician: _____

(Please Print)

Patient Name: _____

Age: _____

Birthdate: _____

Primary Physician: _____

Who referred you to the Orthopedic Center? _____

What is your reason for visit? _____

Date of Onset/Injury: _____

List Current Medications:	
_____	_____
_____	_____
_____	_____

Allergies:

Past Surgical History: _____

Do you smoke cigarettes? Y N How many packs/day? _____ How many years? _____

If you quit, when? _____ Do you use prohibited substances? Y N

Do you drink alcohol? Y N What? _____ How much? _____

What is your occupation? _____

Right Hand Dominant Left Hand Dominant

Weight _____ Height _____ Pulse Rate _____

Marital Status: Single Married Divorced Widowed Separated

of children: _____ Are parents Living Deceased

Do you have a family history of:

High Blood Pressure Heart Disease Stroke Diabetes Thyroid Disease Cancer Arthritis Kidney Disease

(Please check all those that apply).

Past Medical Problems

- | | | | | |
|---|--|---|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Liver Disorders | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Peripheral Vascular Disease | <input type="checkbox"/> TIA's |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gastritis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Seizures | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Kidney Disorders | <input type="checkbox"/> Sickle Cell | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Cardiac Arrhythmia's | <input type="checkbox"/> Mitral Prolapse | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Other Arthritic Conditions |
| | | <input type="checkbox"/> Gout | | |

(Please check all those that apply).

Review of Systems:

- Constitutional: Fevers Chills Night sweats
-
- Eyes: Double vision Watery eyes Itching eyes
-
- ENT: Nose bleeds Bleeding gums Hoarseness Swollen glands Ringing in the ears
-
- Cardiovascular: Chest pain Palpitations Swelling of the ankles
-
- Respiratory: Cough Sputum Wheezing Pleurisy Shortness of breath
-
- Gastrointestinal: Heartburn Reflux Jaundice Nausea
-
- Genito-urinary: Frequency Burning Incontinence
-
- Neurologic: Seizures Dizziness Headaches Balance Disturbances
-
- Endocrine: Excessive thirst Excess weight gain Excess weight loss
-
- Hematologic: Easy bruising Bleeding problems Past blood transfusion
-
- Psychiatric: Anxiety Depression Mood changes Nervousness
-
- Allergy: Itching Environmental Severe topical sensitivities
-
- Skin: Rashes Hives Color changes
-
- Musculoskeletal: Joint pain Joint swelling Cramps Stiffness

INITIAL VISIT:

I have read the statements and answers to the above question. I affirm that they are complete and true to the best of my knowledge and belief.

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

FOLLOW UP VISIT:

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____



Confidential Health History — Update —

(Please Print)

Patient Name: _____ Today's Date: _____

What are you here for today: _____

Date of Onset/Injury: _____

If accident how did it happen: _____

Who is your current primary care physician: _____

Since your last visit :

Have you been diagnosed with any medical problems? _____

Yes No

Have you had any significant change in your health? _____

Yes No

Have you been hospitalized? _____

Yes No

Have you had any surgery? _____

Yes No

Has anyone prescribed you any new medications? _____

Yes No

Have you had any new injuries? _____

Yes No

Is there anything else the doctor should know: _____

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____