Print Form

Tri State Orthopaedic

Patient Health History

It is important for you to fill this form out as completely as possible—there are 2 pages to this form

Name _____ **Birth Date** _____

Primary Care Physician _____ **Pharmacy** _____

CURRENT MEDICATIONS: Are you taking any prescription medications? No ☐ Yes ☐ Please list medications below.

_____ _____
_____ _____
_____ _____
_____ _____

MEDICATION ALLERGIES: Are you allergic to any medications? No ☐ Yes ☐ Please list medications below.

MEDICATION		**REACTION**
_____	----------	_____
_____	----------	_____
_____	----------	_____
_____	----------	_____

NON-MEDICATION ALLERGIES:

SEAFOOD No ☐ Yes ☐ Reaction: _____
LATEX No ☐ Yes ☐ Reaction: _____
OTHER: _____

PAST HEALTH HISTORY: Have you ever been diagnosed with any of the following problems?

CANCER: ☐ BONE ☐ BREAST ☐ LUNG ☐ LYMPHOMA ☐ MULTIPLE MYELOMA ☐ PROSTATE
OTHER: _____

Past Medical History – Please check all that apply

- ☐ **Anemia**
- ☐ **Anxiety Disorder**
- ☐ **Arthritis**
- ☐ **Asthma**
- ☐ **Bleeding Disorder**
- ☐ **Blood Clots**
- ☐ **Cancer**
- ☐ **Coronary Artery Disease**
- ☐ **Depression**
- ☐ **Diabetes**
- ☐ **Gerd/Reflux**
- ☐ **Gout**
- ☐ **HIV-AIDS**
- ☐ **Heart Attack**
- ☐ **Heart Disease**
- ☐ **Heart Problems**
- ☐ **Hepatitis**
- ☐ **Hernia**
- ☐ **Hypertension**
- ☐ **Kidney Disease**
- ☐ **Leg/Foot Ulcers**
- ☐ **Liver Disease**
- ☐ **Lung Disease**
- ☐ **Migraines**
- ☐ **Osteoporosis**
- ☐ **Pacemaker**
- ☐ **Peripheral Vascular Disease**
- ☐ **Rheumatoid Arthritis**
- ☐ **Seizures/Epilepsy**
- ☐ **Stroke**
- ☐ **Thyroid Problems**
- ☐ **Tuberculosis**
- ☐ **Ulcers**

SURGERIES and HOSPITALIZATIONS: Have you had any type of surgery? ☐ No ☐ Yes. Please list type and date:

_____

NAME: _____

FAMILY HISORY: IF ALL HEALTHY CHECK HERE

CANCER: Type _____ Mother ☐ Father ☐ Brother ☐ Sister ☐

HEART and BLOOD

HEART DISEASE Mother ☐ Father ☐ Brother ☐ Sister ☐
HYPERTENSION Mother ☐ Father ☐ Brother ☐ Sister ☐
BLEEDING/CLOTTING PROBLEM Mother ☐ Father ☐ Brother ☐ Sister ☐
DIABETES Mother ☐ Father ☐ Brother ☐ Sister ☐

BLOOD and JOINTS

ARTHRITIS Mother ☐ Father ☐ Brother ☐ Sister ☐

SPECIFIC ANESTHESIA PROBLEMS Mother ☐ Father ☐ Brother ☐ Sister ☐

SOCIAL HISTORY:

YOUR OCCUPATION _____ RETIRED? Yes ☐ No ☐

HAVE YOU EVER USED TOBACCO PRODUCTS? ☐No ☐Yes Please list type(s) of tobacco and frequency of use.

TYPE OF TOBACCO	AMOUNT PER DAY	FROM(year) TO (year)
_____	------ _____	-------- _____

DO YOU CONSUME ALCOHOL? ☐No ☐Yes Please list the type of alcohol and usage

TYPE	HOW MUCH	HOW OFTEN
_____	------- _____	------ _____

WHICH IS YOUR DOMINANT HAND? ☐LEFT ☐ RIGHT ☐NEITHER IS DOMINANT

EXERCISE LEVEL:

NONE ☐ REGULARLY (1-2 TIMES WK) ☐ REGULARLY (3 OR MORE TIMES WK) ☐ OTHER _____

LIVING SITUATION: LIVING WITH or IN THE FOLLOWING SETTING…

ALONE ☐ SPOUSE ☐ CHILDREN ☐ PARENTS ☐ NURSING HOME ☐ ASSISTED LIVING ☐
OTHER _____

SYSTEMS REVIEW: MARK YES or NO AND CHECK ANY OF THE FOLLOWING YOU HAVE HAD RECENTLY

CONSTITUTIONAL SYMPTOMS ☐NO ☐YES
FATIGUE ☐ FEVER ☐ SLEEPING PROBLEMS ☐
UNINTENTIONAL WEIGHT LOSS ☐

CARDIOVASCULAR PROBLEMS ☐NO ☐YES
FAINTING ☐ CHEST PAIN ☐
BLUISH LIPS/FINGERNAILS ☐
IRREGULAR HEARTBEAT ☐
LEG CRAMPS ☐ SWELLING OF ANKLES ☐

RESPIRATORY PROBLEMS ☐NO ☐YES
FREQ NON-PRODUCTIVE COUGH ☐ WHEEZING ☐
FREQ PRODUCTIVE COUGH ☐ SHORTNESS OF BREATH ☐

GASTROINTESTINAL PROBLEMS ☐NO ☐YES
ABDOMINAL PAIN ☐ DIARRHEA ☐ HEARTBURN ☐
NAUSEA ☐ VOMITING ☐

ENDOCRINE PROBLEMS ☐NO ☐YES
INCREASED APPETITE ☐ FEEL COLD ☐
FEEL HOT ☐ INCREASED FATIGUE ☐
UNWANTED WEIGHT CHANGE ☐ NECK ENLARGED ☐

MUSCULOSKELETAL ☐NO ☐YES
PAIN IN BACK ☐ PAIN IN NECK ☐ PAINFUL JOINTS ☐
STIFFNESS IN JOINTS ☐ SWELLING IN JOINTS ☐

NEUROLOGIC PROBLEMS ☐NO ☐YES
CHANGE IN ALERTNESS ☐ HEADACHE ☐
LOSS OF BLADDER CONTROL ☐ NUMBNESS ☐
LOSS OF CONSCIOUSNESS ☐ SEVER FACE PAIN ☐
SEIZURES ☐ WEAKNESS ☐

HEMATOLOGIC/LYMPHATIC PROBLEMS ☐NO ☐YES
BLEEDING EXCESSIVELY AFTER INJURY ☐
BRUISE EASY ☐ NECK MASSES/LUMPS ☐

ALLERGIC PROBLEMS ☐NO ☐YES
FOOD INTOLERANCE ☐ FREQ SNEEZING ☐
SEVERE REACTION TO INSECT BITE ☐ HIVES ☐

GENITOURINARY PROBLEMS ☐NO ☐YES
BLOOD IN URINE ☐ PAINFUL URINATION ☐
DIFFICULTY STARTING/STOPPING URINATION ☐

WHAT IS THE MAIN REASON YOU ARE SEEING THE DOCTOR TODAY?

_____