Name:
DOB:
Chart:
Age:
Date:

ORTHOPAEDIC ASSOCIATES PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible.

Social Security Number (SSN): _____ Appointment Date: _____

Full Name: _____ Gender: _____ Date of Birth: _____

Who makes your healthcare decisions? _____

Relationship: _____ Telephone Number ( ) _____

Medication List: - *List prescribed medications, vitamins, herbal, inhalers, diet supplements*

Medication	Dosage	Reason for taking this medication

Allergies:

Type	Reaction

Non-Medication Allergies:

Are you allergic to any of the following:

Adhesive Tape	☐ No	☐ Yes
Iodine	☐ No	☐ Yes
Contrast dye	☐ No	☐ Yes
Metal	☐ No	☐ Yes
Latex	☐ No	☐ Yes
Family History of MH	☐ No	☐ Yes

Implanted devices _____

Prosthesis (type): _____

Hearing aid (R/L): _____

Dentures/Partial (upper/lower): _____

Glasses/contacts (R/L): _____

If you ever received a cortisone or steroid injection, please list the body part and how many times it has been injected.

_____

Do you have any history of:

- ☐ High blood pressure
- ☐ Frequent headaches
- ☐ Ulcer/stomach pain
- ☐ Kidney disease
- ☐ Jaundice/Liver disease
- ☐ Diabetes type _____
- ☐ Mental illness
- ☐ Spinal cord injury
- ☐ Blood clots
- ☐ HIV/AIDS
- ☐ Heart attack
- ☐ Angina
- ☐ Heart murmur
- ☐ Sleep Apnea
- ☐ Anemia
- ☐ Seizures/Epilepsy
- ☐ Stroke
- ☐ Fainting spells
- ☐ Paralysis
- ☐ Eczema/Psoriasis
- ☐ Depression
- ☐ Arthritis, type _____
- ☐ Cancer, type _____
- ☐ Excessive bleeding
- ☐ Asthma/Bronchitis/COPD
- ☐ Blood transfusion
- ☐ Thyroid disease
- ☐ Sickle cell disease
- ☐ High cholesterol/Lipids
- ☐ Other, _____

Surgeries:

Procedure	Hospital	Date

Name:
DOB:
Chart:
Age:
Date:

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Family Health History:

Please list any problems that run in your family to include bad reactions to anesthesia, easily bruised or bleeding, diabetes, cancer, heart attack before age of 55, arthritis, etc.

	Age	Significant Health Problems		Age	Significant Health Problems
Father			Child	☐ M ☐ F	
Mother			Child	☐ M ☐ F	
Sibling	☐ M ☐ F		Child	☐ M ☐ F	
Sibling	☐ M ☐ F		Grandparents	☐ M ☐ F	

Bone Health: *Check any of the below that you have had.*

- ☐ Fracture from a fall or low impact injury
- ☐ Fracture of the wrist, spine or hip
- ☐ Vitamin D Deficiency
- ☐ Frequent Falls
- ☐ Long term use of steroids (Name of steroid and what you took it for)

_____

- ☐ Had a Bone Mineral Density Test (DXA Scan). If yes, when and where?

_____

- ☐ Had treatment for Osteoporosis. If yes, what and when?

_____

Social History:

☐ Work in the home ☐ Employed (occupation_____) ☐ Student ☐ Daycare ☐ Retired
☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
Children? ☐ No ☐ Yes, #_____
Do you live alone? ☐ No ☐ Yes
Exercise? ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never
What type of exercise? _____
History of substance abuse? ☐ No ☐ Yes What? _____
Smoke currently? ☐ No ☐ Yes Packs per day _____ for _____ years
Quit smoking? ☐ This year ☐ Less than a year ☐ Less than five years ☐ Less than 10 years
Previously smoked _____ packs per day for _____ years
Drink alcohol? ☐ Daily ☐ 1-2 times a week ☐ 1-2 times per month ☐ 1-2 times per year

Review of Systems:

Mark yes or no and CHECK any of the following you have recently had:

Constitutional Symptoms ☐ **No** ☐ **Yes**
☐ Fatigue ☐ Fever ☐ General aching ☐ Night sweats
☐ Unintentional weight gain ☐ Unintentional weight loss

Eye Problems ☐ **No** ☐ **Yes**
☐ Blurred vision ☐ Red eye ☐ Sensitivity to light

Cardiovascular Problems ☐ **No** ☐ **Yes**
☐ Blacking out or fainting ☐ Chest pain
☐ Irregular heart beat

Respiratory Problems ☐ **No** ☐ **Yes**
☐ Frequent productive cough ☐ Shortness of breath
☐ Wheezing

Abdominal Pain ☐ **No** ☐ **Yes**
☐ Change in bowel habits ☐ Nausea ☐ Vomiting

Neurologic Problems ☐ **No** ☐ **Yes**
☐ Difficulty walking ☐ Numbness ☐ Tingling

Psychiatric Problems ☐ **No** ☐ **Yes**
☐ Feels nervous (anxiety) ☐ Feels sad (depression)
☐ Trouble sleeping

Endocrine Problems ☐ **No** ☐ **Yes**
☐ Feels cold

Hematologic/Lymphatic Problems ☐ **No** ☐ **Yes**
☐ Bruises easily

Allergic, Infectious, immunologic ☐ **No** ☐ **Yes**
☐ Infections recurring

Patient Signature: _____ Date: _____

TO ALL FEMALE PATIENTS: For your safety, if you are pregnant or think you may be pregnant, inform the doctor prior to your x-ray examination.

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