

The Center for Orthopedic Surgery

Health History Questionnaire

Patient's name: _____
 Primary Care Physician: _____
 Referral Source: _____

DOB: _____
 Today's date: _____

Past Medical History: Check any illnesses you may have or have had in the past.

- | | | |
|---|--|--|
| <input type="checkbox"/> NONE | <input type="checkbox"/> Peripheral Vascular Disease | <input type="checkbox"/> Frequent UTI's |
| <input type="checkbox"/> CPAP | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Frequent Infections |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Stroke | <input type="checkbox"/> Insulin Dependent |
| <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Non-Insulin Dependent |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Stent Placement | <input type="checkbox"/> Gastric Ulcer |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> IVC Filter | <input type="checkbox"/> Dental Problems |
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Cancer: specify _____ | | |
| <input type="checkbox"/> Hepatitis: specify _____ | | |
| <input type="checkbox"/> Other: _____ | | |

Do you have a Cardiologist: Yes No

Name of the Cardiologist: _____

Past Surgical History: Check any surgeries that you have already had.

- | | | | |
|---|---------------------------------------|--|--|
| <input type="checkbox"/> NONE | <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Gall Bladder | <input type="checkbox"/> Vascular bypass |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Tonsillectomy | <input type="checkbox"/> Fem-pop bypass |
| <input type="checkbox"/> Total joint replacement: specify _____ | | | |
| <input type="checkbox"/> Back Surgery: specify _____ | | | |
| <input type="checkbox"/> Fracture Repair: specify _____ | | | |
| <input type="checkbox"/> Surgery on legs: specify _____ | | | |
| <input type="checkbox"/> Other: _____ | | | |

Medications: Use the back of this page if additional space is needed. Remember antibiotics, blood thinners, Insulin, and heart medications.

NONE

| Name | Strength | Frequency | Name | Strength | Frequency |
|------|----------|-----------|------|----------|-----------|
| | | | | | |
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| | | | | | |
| | | | | | |
| | | | | | |

Allergies: Check all that apply.

- | | | | |
|--|---------------------------------------|-------------------------------------|---------------------------------|
| <input type="checkbox"/> NO KNOWN DRUG ALLERGIES | <input type="checkbox"/> Anesthetic | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Iodine |
| <input type="checkbox"/> Demerol | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Codeine | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Morphine | <input type="checkbox"/> Other: _____ | | |

THIS INFORMATION IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE:

Signature of the person filling out form: _____ date: _____

Patient: _____ Height: _____ Weight: _____ BMI: _____

Social History: Please check. Married Widowed Divorced Single

Do you smoke? yes no Packs/Day: _____ Number of years you have smoked: _____

Do you drink alcohol? yes no Drinks/Week: _____

Occupation: _____

Family History: Please check all that have significance in your family's history, not your own history.

NONE

Father has Arthritis, Diabetes, Heart disease, Stroke, Cancer. Deceased. Other: _____

Mother has Arthritis, Diabetes, Heart disease, Stroke, Cancer. Deceased. Other: _____

Siblings have Arthritis, Diabetes, Heart disease, Stroke, Cancer. Deceased. Other: _____

List family history of orthopedic problems: _____

Other: _____

Review of systems: Circle all symptoms that apply to you from each of the 14 categories.

| | | | |
|-------------------------------|-----------------------------|--------------------------------|------|
| 1. Constitutional | Night sweats | Fever/chills | NONE |
| | Unexpected weight loss/gain | Lbs in the last year? | |
| 2. Eyes | Visual changes | Glasses or Contacts | NONE |
| 3. Ears, nose, throat | Hearing problems | Sore throat | NONE |
| | Cold | Sinus allergies | |
| 4. Cardiovascular | Chest Pain | Palpitations | NONE |
| | Leg swelling | Calf cramps with walking | |
| 5. Respiratory | Shortness of breath | Wheezing | NONE |
| | Frequent cough | Coughing up blood | |
| 6. Gastrointestinal | Ulcer | Bowel/bladder control problems | NONE |
| | Diarrhea | Vomiting | |
| 7. Genitourinary | Incontinence | Burning while urinating | NONE |
| | Blood in urine | Kidney stones | |
| 8. Musculoskeletal | Back ache | Joint stiffness | NONE |
| | Joint swelling | Joint pain | |
| 9. Integumentary | Rash | Hair problem | NONE |
| | Nail problem | | |
| 10. Neurological | Headaches | Memory loss | NONE |
| | Fainting | Tingling and numbness | |
| 11. Psychiatric | Depression | Nervousness | NONE |
| | Personality change | Previous psychiatric care | |
| 12. Endocrine | Excessive urination | Excessive thirst | NONE |
| | Intolerance to heat/cold | | |
| 13. Hematologic/ Lymphatic | Abnormal bleeding | Anemia | NONE |
| 14. Allergic/Immunologic | Immunization problems | Allergy shots | NONE |

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Signature of the person filling out form: _____ date: _____