

Health History Form

General Medical Information

PATIENT NAME: _____ **DATE OF BIRTH:** _____

Allergies: NONE Medications Latex Food Other

List Allergies: _____

Height _____ **Weight** _____

CHECK ONLY IF YOU **HAVE** OR **EVER HAVE HAD:**

Respiratory/Lungs	<input type="checkbox"/> No Problems
--------------------------	---

- | | |
|--|--|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> TB or Positive Test |
| <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Asthma/Wheezing | <input type="checkbox"/> Loud Snoring/Apnea |

Vascular/Heart	<input type="checkbox"/> No Problems
-----------------------	---

- | | |
|--|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Phlebitis/Blood Clots |
| <input type="checkbox"/> Abnormal EKG | <input type="checkbox"/> Circulation Problems |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Chest Pain/Pressure | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Heart Attach/Blockage | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Swelling Feet/Ankles/Legs | <input type="checkbox"/> Irregular Heartbeat |

Blood	<input type="checkbox"/> No Problems
--------------	---

- | | |
|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Easy Bruising |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Frequent Nosebleeds |

Neuro/Brain/Spine	<input type="checkbox"/> No Problems
--------------------------	---

- | | |
|--|---|
| <input type="checkbox"/> Frequent/Severe Headaches | <input type="checkbox"/> Numbness/Tingling |
| <input type="checkbox"/> Back/Neck Pain | <input type="checkbox"/> Paralysis/Weakness |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Sciatica | <input type="checkbox"/> Seizures |

Psychiatric	<input type="checkbox"/> No Problems
--------------------	---

- | | |
|--------------------------------------|---|
| <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Anxiety/Depression |
| <input type="checkbox"/> Anger | <input type="checkbox"/> Hallucinations |

Genitourinary	<input type="checkbox"/> No Problems
----------------------	---

- | | |
|--|-------------------------------------|
| <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Infections |
|--|-------------------------------------|

****If you have a Cardiologist, please list:** _____

Eyes/Ears/Nose/Throat	<input type="checkbox"/> No Problems
------------------------------	---

- | | |
|--|---|
| <input type="checkbox"/> Visual Impairment | <input type="checkbox"/> Hearing Impairment |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Ringing In Ears |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Sinus Problems |

GI/Bowel/Digestive	<input type="checkbox"/> No Problems
---------------------------	---

- | | |
|--|---|
| <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Jaundice/Hepatitis |
| <input type="checkbox"/> Recurrent Nausea | <input type="checkbox"/> Cirrhosis of Liver |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Chronic Diarrhea |
| <input type="checkbox"/> Chronic Constipation | <input type="checkbox"/> Stomach Ulcer |
| <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Rectal Bleeding |
| <input type="checkbox"/> Recurrent Vomiting | |

Endocrine	<input type="checkbox"/> No Problems
------------------	---

- | | |
|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Low Blood Sugar |
| <input type="checkbox"/> Hormone Disorders | <input type="checkbox"/> Thyroid Disorder |

Musculoskeletal	<input type="checkbox"/> No Problems
------------------------	---

- | | |
|---|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> History of Fractures | <input type="checkbox"/> Joint Replacements |
| <input type="checkbox"/> Muscle Disease | <input type="checkbox"/> Physical Limitations |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Gout |

Skin	<input type="checkbox"/> No Problems
-------------	---

- | | |
|--|--------------------------------------|
| <input type="checkbox"/> Non-Healing Sores | <input type="checkbox"/> Ulceration |
| <input type="checkbox"/> Skin Disorder | <input type="checkbox"/> Skin Cancer |

Do you have a history of cancer? No Yes

Type: _____ **Date:** _____

(Form Is Continued On Back)

PATIENT NAME: _____

BIRTH DATE: _____

Medications Taken Regularly (Prescription, Over-The-Counter, Home Remedies)

Medication	Dose & Frequency	Reason For Taking	Effects

Past Surgical History

NO PAST SURGERIES

Year	Surgery / Hospitalization	Complications (If Any)

Family History

Family Member	Age	Health Status/Major Illnesses	If Deceased, Cause of Death	Age at Death
Father				
Mother				
Sister/Brother				
Sister/Brother				
Sister/Brother				
Sister/Brother				

Social History

Do You Have Children? No Yes How Many? _____

Do You Live Alone? No Yes

Exercise? Daily Weekly Monthly Rarely Never What Type Of Exercise? _____

History of Substance Abuse? No Yes How Long? _____ How Much? _____ Type? _____

Do You Smoke? No Yes How Many Packs Per Day? _____ For How Many Years? _____

Did You Smoke In The Past? No Yes When? _____ Packs Per Day? _____ How Many Years? _____

Do You Drink Alcohol? Never 1-2 Times Per Year 1-2 Times Per Month 1-2 Times Per Week

FOR OFFICE USE: Blood Pressure _____ Pulse _____ Temp. _____

I agree that The Center for Joint Surgery & Sports Medicine, a division of Centers for Advanced Orthopaedics may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

Patient Signature: _____ Date: _____

Reviewed By: _____ Date: _____