The Centers for Advanced Orthopaedics
Parkway Division

"A Joint Effort for Joint Success!"
13 Western Maryland Parkway, Ste. 104
Hagerstown, MD 21740
(301) 665.4575
www.hipknee.com

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	**❑ No Problems**
❑ Pneumonia	❑ TB or Positive Test
❑ Chronic Cough	❑ Shortness of Breath
❑ Asthma/Wheezing	❑ Loud Snoring/Apnea

Vascular/Heart	**❑ No Problems**
❑ High Blood Pressure	❑ Phlebitis/Blood Clots
❑ Abnormal EKG	❑ Circulation Problems
❑ Pacemaker	❑ Varicose Veins
❑ Chest Pain/Pressure	❑ Heart Murmur
❑ Heart Attach/Blockage	❑ Fainting
❑ Swelling Feet/Ankles/Legs	❑ Irregular Heartbeat

Blood	**❑ No Problems**
❑ Anemia	❑ Easy Bruising
❑ Bleeding Disorder	❑ Frequent Nosebleeds

Neuro/Brain/Spine	**❑ No Problems**
❑ Frequent/Severe Headaches	❑ Numbness/Tingling
❑ Back/Neck Pain	❑ Paralysis/Weakness
❑ Dizziness	❑ Stroke
❑ Sciatica	❑ Seizures

Psychiatric	**❑ No Problems**
❑ Mood Swings	❑ Anxiety/Depression
❑ Anger	❑ Hallucinations

Genitourinary	**❑ No Problems**
❑ Kidney Stones	❑ Infections

Eyes/Ears/Nose/Throat	**❑ No Problems**
❑ Visual Impairment	❑ Hearing Impairment
❑ Glaucoma	❑ Ringing In Ears
❑ Cataracts	❑ Sinus Problems

GI/Bowel/Digestive	**❑ No Problems**
❑ Difficulty Swallowing	❑ Jaundice/Hepatitis
❑ Recurrent Nausea	❑ Cirrhosis of Liver
❑ Heartburn	❑ Chronic Diarrhea
❑ Chronic Constipation	❑ Stomach Ulcer
❑ Hiatal Hernia	❑ Rectal Bleeding
❑ Recurrent Vomiting	

Endocrine	**❑ No Problems**
❑ Diabetes	❑ Low Blood Sugar
❑ Hormone Disorders	❑ Thyroid Disorder

Musculoskeletal	**❑ No Problems**
❑ Arthritis	❑ Rheumatoid Arthritis
❑ History of Fractures	❑ Joint Replacements
❑ Muscle Disease	❑ Physical Limitations
❑ Osteoporosis	❑ Gout

Skin	**❑ No Problems**
❑ Non-Healing Sores	❑ Ulceration
❑ Skin Disorder	❑ Skin Cancer

Do you have a history of cancer? ❑ No ❑ Yes
Type: ____________________ **Date:** ______

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

(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 Centers for Advanced Orthopaedics-Parkway Division 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:** ________