

# CENTER FOR JOINT SURGERY & SPORTS MEDICINE HEALTH HISTORY

Patient's Name \_\_\_\_\_

Date \_\_\_\_\_

## General Medical Information

**Allergies:**    NONE        Medications        Latex        Food        Other

List Allergies: \_\_\_\_\_

**Height** \_\_\_\_\_        **Weight** \_\_\_\_\_

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

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

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

<b>Vascular/Heart</b>	<input type="checkbox"/> <b>No Problems</b>
<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 Attack/Blockage	<input type="checkbox"/> Fainting
<input type="checkbox"/> Swelling Feet/Ankles/Legs	<input type="checkbox"/> Irregular Heartbeat

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

<b>Blood</b>	<input type="checkbox"/> <b>No Problems</b>
<input type="checkbox"/> Anemia	<input type="checkbox"/> Easy Bruising
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Frequent Nosebleeds

<b>Endocrine</b>	<input type="checkbox"/> <b>No Problems</b>
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Low Blood Sugar
<input type="checkbox"/> Hormone Disorder	<input type="checkbox"/> Thyroid Disorder

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

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

<b>Psychiatric</b>	<input type="checkbox"/> <b>No Problems</b>
<input type="checkbox"/> Mood Swings	<input type="checkbox"/> Anxiety/Depression
<input type="checkbox"/> Anger	<input type="checkbox"/> Hallucinations

<b>Skin</b>	<input type="checkbox"/> <b>No Problems</b>
<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** \_\_\_\_\_

**\*\*If you have a Cardiologist, please list:** \_\_\_\_\_

### MEDICATIONS TAKEN REGULARLY (Prescription, Over-The-Counter, Home Remedies)

Medication	Dose & Frequency	Reason For Taking	Side Effects

(Form Is Continued On Back)

Patient Name \_\_\_\_\_ Birth Date \_\_\_\_\_

**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 the The Center for Joint Surgery & Sports Medicine 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 \_\_\_\_\_