Health History Form

General Medical Information

Patient Name: ______________________ **Birthdate:** ______________

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:** ______________________________

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

Medication	Dose & Frequency	Reason For Taking	Side Effects

(Form Is Continued On Back)

Patient Name: ______________________ **Birthdate:** ______________________

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 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:** __________