

Center for Orthopaedics and Sports Medicine, Inc
PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. This is very important information. **Please fill out every item.** It is important for your doctor to know that you have carefully reviewed every area of this form. This information will be entered into the computer system.

Patient Name: _____ M F Date of Birth: _____ Appt. Date: _____

Mobile Phone: _____ Height _____ Weight _____

Name of Primary Care (Family) Physician _____ Consult Requested By: _____

Today's Problem: _____

Date of onset: _____ Recurrences if any: _____

How did it happen: _____

Where did it happen: _____

Prior treatment for this problem, if any : _____

Any X-Rays / MRI done? No Yes If so, where? _____ What date? _____

Are you taking ANY kind of medication now? No Yes If yes, please list below.

Medication Name	Dosage/ How was it Prescribed?

Are you allergic to any medications? No Yes If yes, please list below.

Medication Name	Type of Reaction

Non-Medication Allergies

Are you allergic to any non-medical things such as latex, tape, metal? No Yes. If yes, specify: _____

Are you allergic to contrast dye? No Yes

Past Health History

- Cancer No Yes Type _____
- Heart Attack No Yes
- Heart Disease No Yes
- Hypertension No Yes
- Asthma No Yes
- Bursitis No Yes
- Gastritis No Yes

- Stomach Ulcer No Yes
- Arthritis No Yes Type _____
- Stroke No Yes
- Anxiety No Yes
- Fractures No Yes
- Diabetes No Yes Type _____
- Major Infection No Yes

Surgeries and Hospitalizations

Have had problems with anesthesia (being numbered or put to sleep)? No Yes

If yes please list what type of problems _____

Have you ever had surgery before? No Yes

If yes, please list all surgeries:

Family History

Father – Alive? No ___Age Deceased Yes
Father Health Status Good Fair Poor
Mother – Alive? No ___Age Deceased Yes
Mother Health Status Good Fair Poor

Heart Disease Father Mother Brother Sister
Hypertension Father Mother Brother Sister
Asthma Father Mother Brother Sister
COPD Father Mother Brother Sister
Arthritis Father Mother Brother Sister
Osteoporosis Father Mother Brother Sister
Stroke Father Mother Brother Sister
Diabetes before age 18 Father Mother Brother Sister
Diabetes after age 18 Father Mother Brother Sister
Bleeding problems Father Mother Brother Sister

Social History

What is your occupation? _____ Check here if you are retired
Marital Status: Single Married Divorced Separated Widowed
Tobacco Use: None Current packs per day _____
Alcohol Use: None Socially Rarely Moderately Heavily
Drug Use: None Type/Frequency _____
Exposure at home or work to: Smoke Fumes other: _____
Which is your dominant hand? Right Left Neither (Ambidextrous)

REVIEW OF SYSTEMS

Problems you have or have had recently in the following areas: (Circle the symptom you are having.)

General Constitutional (fever, fever and chills, weight gain, weight loss) No Yes
Eyes (eye pain, red eyes) No Yes
ENT (dizziness, hearing loss, ear pain, nosebleeds, sore throat) No Yes
Heart and Blood Vessels (chest pain, irregular heart beat, swelling) No Yes
Lungs and respiratory system (non-productive cough, productive cough, coughing up blood)

Stomach and digestive system (abdominal pain, frequent nausea, frequent vomiting) No Yes
Bones, Joints, or Muscles (cramping, pain in back, painful joints, stiffness, weakness) No Yes
Brain and nervous system (change in alertness, frequent headache, frequent face pain seizures, loss of consciousness, tingling) No Yes
Mental and Emotional Health (trouble sleeping, anxiety, depression) No Yes
Endocrine (increased appetite, increased fatigue, increased thirst, enlarged neck, pain in neck) No Yes
Allergies, infections, immune system (frequent infections, severe reaction to insect bite) No Yes

Patient/Guardian Signature _____ Date _____

Patient Name: _____ Witness _____