HEALTH HISTORY

Name__________________ Age________ Today's Date______________

Family Physician__________________ Referred by__________________

WHY ARE YOU SEEING THE DOCTOR TODAY?

AREA OF PROBLEM

	Left	Right
❐ Finger(s)	❐	❐
❐ Hand	❐	❐
❐ Wrist	❐	❐
❐ Forearm	❐	❐
❐ Elbow	❐	❐
❐ Arm	❐	❐
❐ Shoulder	❐	❐
❐ Neck	❐	❐
❐ Back	❐	❐
❐ Hip	❐	❐
❐ Thigh	❐	❐
❐ Knee	❐	❐
❐ Leg	❐	❐
❐ Ankle	❐	❐
❐ Foot	❐	❐
❐ Toe(s)	❐	❐
Dominant Hand	❐	❐

Height______________

Weight______________

NATURE OF PROBLEM

❐ Pain ❐ Swelling
❐ Redness ❐ Bruising
❐ Stiffness ❐ Weakness
❐ Numbness ❐ Tingling
❐ Deformity ❐ __________

Any injury? ❐ Yes ❐ No

If yes, nature of injury:__________

____

Date of injury______________

Work Related ❐ Yes ❐ No

Prior Treatment ❐ Yes ❐ No

If yes, by whom:

❐ Emergency Room
❐ Family Doctor
❐ Another Orthopedist
❐ Other______________

Are you allergic to latex? ❐ Yes ❐ No

Are you allergic to any metals or jewelry? ❐ Yes ❐ No

When was your last bone density exam?__________________

ONSET & DURATION

(Current episode)

When problem first noted? (Date)__________________

❐ Sudden Onset ❐ Gradual Onset

❐ Improving
❐ Worsening
❐ Same

Activities that aggravate symptoms:

____

____

Activities that relieve symptoms:

____

____

PRIOR EPISODES ❐ Yes ❐ No

If yes, when:__________________

____

Are you postmenopausal? ❐ Yes ❐ No

CONDITIONS Check ☑ conditions that you have or have had in the past.

❐ AIDS/HIV Positive
❐ Alcoholism
❐ Anemia
❐ Arthritis
❐ Asthma
❐ Bleeding Disorder
❐ Blood Clots
❐ Bronchitis
❐ Cancer
❐ Chemical Dependency
❐ Circulation Problem
❐ Depression
❐ Diabetes
❐ Emphysema
❐ Epilepsy
❐ Fibromyalgia
❐ Glaucoma
❐ Gout
❐ Heart Disease
❐ Hepatitis
❐ Herpes/STD
❐ High Blood Pressure
❐ High Cholesterol
❐ Kidney Disease
❐ Liver Disease
❐ Lupus
❐ Migraine Headaches
❐ Mitral Valve Prolapse
❐ Multiple Sclerosis
❐ Pacemaker
❐ Pneumonia
❐ Polio
❐ Prostate Problem
❐ Psoriasis
❐ Psychiatric Condition
❐ Rheumatic Fever
❐ Sleep Apnea
  ❐ on C-PAP
❐ Stroke
❐ Thyroid Problem
❐ Tuberculosis
❐ Ulcer/Acid Reflux/GERD
❐ __________________
❐ __________________

MEDICATIONS List medications you are currently taking. Include dose and frequency.

____

____

____

____

____

None ❐

ALLERGIES (to medications or substances) and **NATURE** of **REACTION**:

____

____

____

____

____

None ❐

Pharmacy Name__________________ Phone__________________

COMPLETE BACK ⇨

LIFESTYLE HABITS
Which substances do you use and how often?

- ❒ Alcohol ______________________
- ❒ Caffeine ______________________
- ❒ Drugs ______________________
- ❒ Tobacco ______________________
- ❒ Other ______________________

SERIOUS ILLNESSES/INJURIES

SERIOUS ILLNESSES/INJURIES	DATE	OUTCOME

OCCUPATION AND JOB DESCRIPTION

____
____
____

SURGERIES AND HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had an anesthetic complication? ❒ Yes ❒ No

Have you ever had a blood transfusion? ❒ Yes ❒ No
If yes, please give approximate date(s) ______________________

Have any of your blood relatives ever had . . .

- Anesthetic complications? ❒ Yes ❒ No
- Bleeding disorder? ❒ Yes ❒ No
- Blood clots? ❒ Yes ❒ No
- Bone disorder? ❒ Yes ❒ No
- Rheumatoid arthritis? ❒ Yes ❒ No

FAMILY HISTORY

FAMILY HISTORY	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brother				
Brother				
Brother				
Sister				
Sister				
Sister				

REVIEW OF SYSTEMS
Check ☑ any health problems that pertain to you.

General
- ❒ Fatigue
- ❒ Fever
- ❒ Night sweats
- ❒ Weakness
- ❒ Weight gain/loss

Eyes
- ❒ Corrective eyewear
- ❒ Eye pain
- ❒ Visual disturbance

Ear/Nose/Throat/Mouth
- ❒ Earache
- ❒ Frequent nose bleed
- ❒ Hearing loss
- ❒ Sinus pain
- ❒ Sore throat
- ❒ Tooth/gum problems

Respiratory
- ❒ Cough
- ❒ Coughing up blood
- ❒ Shortness of breath
- ❒ Wheezing

Cardiovascular
- ❒ Chest pain
- ❒ Fainting spells
- ❒ Palpitations
- ❒ Racing heart rate
- ❒ Swollen ankles

Gastrointestinal
- ❒ Abdominal pain
- ❒ Bloody stools
- ❒ Diarrhea
- ❒ Heartburn
- ❒ Loss of appetite
- ❒ Nausea
- ❒ Vomiting ❒ Bloody

Genitourinary
- ❒ Bloody urine
- ❒ Incontinence
- ❒ Painful urination

Allergy/Immunologic
- ❒ Frequent infections
- ❒ Runny nose/sneezing
- ❒ Skin sensitivities

Neurological
- ❒ Balance problems
- ❒ Dizziness/lightheadness
- ❒ Excessive headaches
- ❒ Memory loss or confusion
- ❒ Numbness/weakness
- ❒ Tremors/seizures

Metabolic/Endocrine
- ❒ Excessive thirst/urination
- ❒ Glandular or hormone problems
- ❒ Heat/cold intolerance

Dermatological
- ❒ Open wounds/sores
- ❒ Rash

Hematological
- ❒ Bruise easily
- ❒ Easy/persistent bleeding

Psychiatric
- ❒ Agitation
- ❒ Depression
- ❒ Insomnia
- ❒ Suicidal

I certify that the above information is correct to the best of my knowledge. I will not hold the doctor or any members of his/her staff responsible for any errors or omissions that may have been made in the completion of this form.

Signature____ Date______________________