

HEALTH HISTORY FORM



Patient Name:
Patient #:
Date of Birth:
Primary Care Physician:

Date:

PATIENT MEDICAL HISTORY. Check all that apply.

- | | | |
|--|--|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Eczema | <input type="checkbox"/> Peptic ulcer disease |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Peripheral vascular disease |
| <input type="checkbox"/> Acid reflux | <input type="checkbox"/> Fracture _____ | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Gout | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Renal failure |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Seizure disorder |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Kidney disease/stones | <input type="checkbox"/> Sickle cell disease |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Lupus (erythematosis) | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Chronic obstructive pulmonary disease | <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Valvular heart disease |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Neuropathy | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Osteoporosis/osteopenia | <input type="checkbox"/> _____ |
| | <input type="checkbox"/> Parkinson's disease | |

PAST SURGICAL HISTORY. Check all that apply.

- | | | |
|--|---|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Sinus surgery | <input type="checkbox"/> Hip replacement |
| <input type="checkbox"/> Adenoidectomy | <input type="checkbox"/> Tonsillectomy | <input type="checkbox"/> Knee replacement |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Back Surgery _____ | <input type="checkbox"/> Meniscus surgery |
| <input type="checkbox"/> Bowel resection | <input type="checkbox"/> _____ | <input type="checkbox"/> Nerve repair |
| <input type="checkbox"/> Breast _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> Rotator cuff repair |
| <input type="checkbox"/> Cataract excision | | <input type="checkbox"/> Shoulder replacement |
| <input type="checkbox"/> Caesarean section | | <input type="checkbox"/> Tendon repair |
| <input type="checkbox"/> Coronary artery angioplasty | | <input type="checkbox"/> Trigger finger release |
| <input type="checkbox"/> Cholecystectomy | | <input type="checkbox"/> Ulnar nerve decompression |
| <input type="checkbox"/> Heart bypass | | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Hernia repair | | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Hysterectomy | | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Removal of both ovaries | | |

Past Orthopaedic Surgery

REVIEW OF SYSTEMS. Check all that apply.

Musculoskeletal

- Joint pain
- Joint stiffness/swelling
- Weakness of muscles/joints
- Muscle pain/cramps
- Back pain
- Cold extremities
- Difficulty in walking

Constitutional Symptoms

- Bad general health lately
- Recent weight change
- Fever
- Fatigue
- Headaches

Neurological

- Numbness or tingling
- Tremors
- Paralysis
- Lightheaded/Dizzy

Hematologic

- Cuts slow to heal
- Tendency to bleed/bruise
- Anemia
- Enlarged glands

Gastrointestinal

- Loss of appetite
- Nausea/vomiting
- Frequent diarrhea
- Constipation
- Abdominal pain

Genitourinary

- Frequent urination
- Burning/pain urinating
- Blood in urine
- Incontinence

Integumentary (Skin)

- Rash or itching
- Changes in skin color
- Varicose veins

Cardiovascular

- Chest pain
- Palpitations
- Shortness of breath when walking
- Swelling of hands/feet

Psychiatric

- Memory loss
- Nervousness
- Depression

- Insomnia

Respiratory

- Spitting up blood
- Short of breath
- Wheezing
- Chronic cough

Eyes/Ears/Mouth

- Eye disease or injury
- Wear contact lens/glasses
- Hearing aids
- Dentures

Allergies

- No known allergies
- Tape _____
- Erythromycin
- Codeine
- Sulfa
- Metal
- Latex
- Penicillin
- Exam dye (iodine)
- Topical iodine
- _____
- _____

