# 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 electronic medical record.

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

Mobile Phone:_____ Height_____ Weight_____

*Preferred Language:_____ *Race:_____ *Ethnicity:_____
*Federal insurance programs and other insurances that receive federal funding require that we obtain this information. If you do not wish to furnish this information, simply state "decline to state"

E-mail Address: _____
( For office communication only. Will not be disclosed to 3rd party)

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

Preferred Pharmacy (name and city)_____

How did you hear about us: ☐ Physician ☐ Friend/Family ☐ Internet Search ☐ Insurance ☐ Employer ☐ Hospital / ER ☐ Other

**Today's Problem:** _____
Date of onset:_____ Recurrences if any:_____
How did it happen:_____
_____
_____
Where did it happen:_____
Prior treatment for this problem, if any : ☐ Physician / Orthopaedics ☐ Physical Therapy ☐ Medication
Other:_____
_____
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 | Diagnosis |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

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_____ | Stomach Ulcer | ☐ No | ☐ Yes |
| Heart Attack | ☐ No | ☐ Yes | Arthritis | ☐ No | ☐ Yes Type_____ |
| Heart Disease | ☐ No | ☐ Yes | Stroke | ☐ No | ☐ Yes |
| Hypertension | ☐ No | ☐ Yes | Anxiety | ☐ No | ☐ Yes |
| Asthma | ☐ No | ☐ Yes | Fractures | ☐ No | ☐ Yes |
| Bursitis | ☐ No | ☐ Yes | Diabetes | ☐ No | ☐ Yes Type_____ |
| Gastritis | ☐ No | ☐ Yes | Major Infection | ☐ No | ☐ Yes |
| Other | ☐ No | ☐ Yes List_____ | | | |

**Surgeries and Hospitalizations**
Have had problems with anesthesia (being numbed 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: | ☐ None | ☐ 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) | ☐ No ☐ Yes |
| **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 |
| **Neurologic** (fatigue, frequent headache, 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_____