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 ☐ 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_____