CENTER FOR ORTHOPAEDICS & SPORTS MEDICINE HISTORY FORM 1 of 3

The following information is very important to your health. Please take the time to fully and accurately fill out this 3 page form.

Last	First	MI	DOB/AGE		PCP

MEDICAL HISTORY ☐ **NONE**

Have you ever had (Please check and give approximate date of diagnosis)

(age/date)

- ☐ _____ Heart attack
- ☐ _____ High blood pressure
- ☐ _____ Stroke
- ☐ _____ Diabetes
- ☐ _____ Epilepsy/Seizures
- ☐ _____ Asthma
- ☐ _____ Stomach ulcer
- ☐ _____ Hiatal hernia
- ☐ _____ Kidney disease
- ☐ _____ Liver disease
- ☐ _____ Nasal polyps
- ☐ _____ Blood clot or clotting disorder
- ☐ _____ Deep venous thrombosis (DVT)
- ☐ _____ Phlebitis
- ☐ _____ Anesthetic Problems
- ☐ _____ Anemia

(age/date)

- ☐ _____ Rheumatoid arthritis
- ☐ _____ Osteoarthritis
- ☐ _____ Gout
- ☐ _____ Lupus
- ☐ _____ Scleroderma
- ☐ _____ Polio
- ☐ _____ Lyme disease
- ☐ _____ Paget's disease
- ☐ _____ Bone or joint infection
- ☐ _____ Thyroid disease
- ☐ _____ Osteoporosis
- ☐ _____ Tuberculosis
- ☐ _____ Bone tumors
- ☐ _____ Fracture/Broken Bone
- ☐ _____ Cancer _____
- ☐ _____ Other bone or joint disease _____
- ☐ _____ Other _____

- ☐ _____ Blood transfusion (explain) _____
- ☐ _____ Bleeding disorders (explain) _____
- ☐ _____ Hepatitis (circle type) A B C NON A-NON B
- ☐ _____ Sexually transmitted disease (explain) _____
- ☐ _____ AIDS

SURGICAL HISTORY ☐ **NONE**

What operations have you had?
(Please list approximate date at surgery)

(age/date)

- ☐ _____ Hysterectomy/removal of ovaries
- ☐ _____ Appendectomy
- ☐ _____ Tubal ligation
- ☐ _____ Tonsils
- ☐ _____ Gall bladder
- ☐ _____ Neck
- ☐ _____ Back
- ☐ _____ Extremity _____
- ☐ _____ Other _____
- ☐ _____ Other _____
- ☐ _____ Other _____
- ☐ _____ Other _____

FAMILY HISTORY ☐ **NONE**

Does/did anyone in your family have any of the following?
(Include parents, grandparents, siblings)

(relative)

- ☐ _____ Heart disease
- ☐ _____ High blood pressure
- ☐ _____ Diabetes
- ☐ _____ Cancer _____
- ☐ _____ Bleeding disorder
- ☐ _____ Developmental delay
- ☐ _____ Mental illness
- ☐ _____ Substance abuse
- ☐ _____ Osteoporosis
- ☐ _____ Scoliosis
- ☐ _____ Rheumatoid arthritis
- ☐ _____ Scleroderma
- ☐ _____ Lupus
- ☐ _____ Paget's Disease
- ☐ _____ Blood Clot or Clotting Disorder
- ☐ _____ Anesthetic Problems

SOCIAL HISTORY

Do you use tobacco?
☐ Cigarettes ☐ Chewing NO ☐ YES ☐ If YES, how much? For how long? _____
Do you drink alcohol? NO ☐ YES ☐ If YES, how much? For how long? _____
Do you use any street drugs? NO ☐ YES ☐ Explain how much? For how long? _____
Do you have any special interests or hobbies? (list how often you do your hobbies) _____

Do you use any assist devices for walking? ☐ Crutches ☐ Cane ☐ Walker ☐ Wheelchair ☐ Prosthetic ☐ Other _____
How long have you used this device? _____

Last	First	MI	DOB/AGE		PCP

ALLERGIES Are you **allergic** to any medications? ☐ **NONE**

(medication)	(symptom)

Have you had any undesired side effects to any medications?

(medication)	(side effect)

DO YOU HAVE ANY ALLERGY TO LATEX? (please circle) YES NO

MEDICATIONS: What medications do you take? PLEASE LIST THEM BELOW - DO NOT USE ABBREVIATIONS

☐ **NONE**

MEDICATION ☐SEE MEDICATION LIST ATTACHED	DOSAGE Grams, Mg (etc)	How is Medication Taken: (1 time daily, w/meals, night, as needed)	REASON FOR MEDICATION

HERBAL SUPPLEMENTS: What herbs do you take? PLEASE LIST THEM BELOW - DO NOT USE ABBREVIATIONS

HERB	DOSAGE Grams, Mg (etc)	How is Medication Taken: (1 time daily, w/meals, night, as needed)	REASON FOR HERB

CENTER FOR ORTHOPAEDICS & SPORTS MEDICINE – HISTORY FORM PAGE 3 of 3

Last	First	MI	DOB/AGE		PCP

REVIEW OF SYSTEMS: Check any of the following symptoms you have experienced WITHIN THE PAST SIX MONTHS. Check NONE if none apply.

GENERAL
- ☐ NONE
- ❑ Fever or Chills
- ❑ Lack of appetite
- ❑ Fatigue
- ❑ Weakness
- ❑ Recent change in usual weight
- ❑ Other_____

RESPIRATORY
- ☐ NONE
- ❑ Difficulty breathing
- ❑ Persistent cough
- ❑ Shortness of breath
- ❑ Other _____

PSYCHOLOGICAL
- ☐ NONE
- ❑ Depression
- ❑ Tension
- ❑ Nervousness
- ❑ Anxiety disorder
- ❑ Bipolar disorder

Other _____

EYES
- ☐ NONE
- ❑ Eye Infection
- ❑ Change in vision
- ❑ Other _____

GASTROINTESTINAL
- ☐ NONE
- ❑ Heartburn/esophageal reflux
- ❑ Nausea
- ❑ Constipation
- ❑ Loose bowels/diarrhea
- ❑ Other_____

SKIN
- ☐ NONE
- ❑ Bruise easily
- ❑ Rash or Hives
- ❑ Other_____

EARS/NOSE/MOUTH/THROAT
- ☐ NONE
- ❑ Earache
- ❑ Infection or drainage
- ❑ Polyps
- ❑ Nasal congestion
- ❑ Sore throat
- ❑ Sores in mouth
- ❑ Other _____

URINARY
- ☐ NONE
- ❑ Recent urinary tract infection
- ❑ Pain or burning with urination
- ❑ Kidney Stones
- ❑ Other_____

ENDOCRINE
- ☐ NONE
- ❑ Excessive urination
- ❑ Excessive appetite
- ❑ Excessive thirst
- ❑ Other _____

CARDIOVASCULAR
- ☐ NONE
- ❑ Chest pain
- ❑ Irregular heartbeat
- ❑ Palpitations
- ❑ Heart murmur
- ❑ Heart Attack
- ❑ Stroke
- ❑ Other _____

MUSCULOSKELETAL
- ☐ NONE
- ❑ Painful or stiff joints
- ❑ Cramps in muscles
- ❑ Infection of joint
- ❑ Broken Bone/Fracture
- ❑ Other _____

HEMATOLOGY/LYMPH
- ☐ NONE
- ❑ History of transfusion
- ❑ Bleeding disorder
- ❑ Hepatitis
- ❑ AIDS
- ❑ Anemia
- ❑ Other_____

NEUROLOGIC
- ☐ NONE
- ❑ Muscle weakness
- ❑ Numbness or tingling
- ❑ Loss of sensation
- ❑ Other_____

FEMALE HEALTH HISTORY
- ☐ NONE
- ❑ Age of onset of menstrual period _____
- ❑ Age when periods stopped (menopause) ____
- ❑ First day of last menstrual period _____
- ❑ Last mammogram _____
- ❑ Last Pap exam_____

☐ **REVIEWED ALL. NEGATIVE EXCEPT THOSE CHECKED**

The information completed on this three-page History Form is true and correct to the best of my belief.

_____ _____

Signature Date

_____ _____

MA Signature – reviewed pages 1 through 3 with patient Date