S.T.A.R. Orthopedics, Inc.

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General Health Questionnaire

□ Scanned (for office use)

PATIENT INFORMATION

Chief Complaint: ______________________________

Name: ______________________________ Date: ______________

Date of Birth: ______________ Age: ________ SS#: ______________________

Home Address: ______________________ City: ______________ State: ________ Zip: ________

Mailing Address: ______________________ City: ______________ State: ________ Zip: ________

Home #: ______________________ Cell #: ______________________

eMail: ______________________________

Your Height: ______________________ Your Weight: ______________________

Who referred you to our practice? ______________________________

Who is your family doctor? ______________________________

Other treating physicians: ______________________________

PAST MEDICAL HISTORY (Check all that apply)

□ NONE	□ Thyroid Disease	□ Stomach Ulcer
□ Heart Attack	□ Kidney Disease	□ Osteoarthritis
□ Heart Failure	□ Liver Disease	□ Rheumatoid Arthritis
□ Irregular Heart Beat	□ Diabetes	□ Lupus
□ Heart Disease	□ Post Menopausal	□ Osteoporosis
□ Mitral Valve Prolapse	□ Asthma	□ Glaucoma
□ High Blood Pressure	□ Tuberculosis	□ Depression
□ High Cholesterol	□ COPD / Emphysema	□ Anxiety
□ Clotting Problems	□ Anemia	□ Cancer
□ Peripheral Vascular Disease	□ AIDS / HIV+	□ Recurrent Uriniary Tract Infections
□ Stroke or “mini stroke”	□ Hepatitis	□ Chronic Infections

Other Medical Conditions: ______________________________

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PAST SURGICAL HISTORY (Check all that apply)

☐ NONE	☐ Mastectomy (removal of breast)	☐ ______
☐ Cataract	☐ Gastric Bypass	☐ ______
☐ Cardiac Bypass (Open Heart Surgery)	☐ Cholecystectomy (removal of gallbladder)	☐ ______
☐ Cardiac Angioplasty	☐ Appendectomy (removal of appendix)	☐ ______
☐ Cardiac Stent	☐ Colectomy (removal of part of colon)	☐ ______
☐ Pacemaker	☐ Prostate Surgery	☐ ______

ORTHOPEDIC SURGICAL HISTORY (Check all that apply)

☐ NONE

SURGERY	LEFT/RIGHT	DATE (month/year)	SURGEON / HOSPITAL (if known)
☐ Shoulder Arthroscopy			
☐ Shoulder Arthroscopy			
☐ Shoulder Replacement			
☐ Shoulder Replacement			
☐ Hip Arthroscopy			
☐ Hip Arthroscopy			
☐ Hip Replacement			
☐ Hip Replacement			
☐ Knee Arthroscopy			
☐ Knee Arthroscopy			
☐ Knee Replacement			
☐ Knee Replacement			

☐ Childhood Injuries/Broken Bones: ______

☐ Other: ______

ALLERGIES (Check all that apply)

	☐ List Other Allergies:	Reactions:
☐ NONE		
☐ Seasonal/Environmental		
☐ Penicillin (PCN)		
☐ Sulfa		
☐ Codeine		
☐ NSAID's		
☐ Iodine		
☐ Latex		

MEDICATIONS

☐ NONE ☐ Detailed list attached

MEDICATION:	DOSE:	FREQUENCY:

FAMILY HISTORY (Check all that apply)

☐ Alcoholism
☐ Anemia
☐ Arthritis
☐ Asthma
☐ Bleed Easily
☐ Blood Clots
☐ Cancer
☐ Diabetes
☐ Emphysema
☐ Epilepsy
☐ Glaucoma
☐ Heart Disease
☐ High Blood Pressure
☐ High Cholesterol
☐ Osteoporosis
☐ Stroke
☐ Thyroid Disorder
☐ ______________________________
☐ ______________________________
☐ ______________________________
☐ ______________________________

PERSONAL AND SOCIAL HISTORY (Check all that apply)

☐ Handedness	☐ Alcohol	☐ Tobacco	☐ Elicit Drug Use	☐ Narcotics
☐ Right	☐ Social	________ Packs/day	________________	________________
☐ Left	☐ Daily	☐ Cigars		

Occupation:

☐ Retired ☐ Disabled ☐ Unemployed; since: ____

☐ Employed; Occupation: ____

Relationship Status:

☐ Single ☐ Married ☐ Widowed ☐ Child ☐ Other:________________________________