

The Center for Orthopedic Surgery

Health History Questionnaire

Patient's name: _____
 Primary Care Physician: _____

DOB: _____
 Today's date: _____

Past Medical History: Check any illnesses you may have or have had in the past.

- | | | |
|---|--|--|
| <input type="checkbox"/> NONE | <input type="checkbox"/> Peripheral Vascular Disease | <input type="checkbox"/> Frequent UTI's |
| <input type="checkbox"/> CPAP | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Frequent Infections |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Stroke | <input type="checkbox"/> Insulin Dependent |
| <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Non-Insulin Dependent |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Stent Placement | <input type="checkbox"/> Gastric Ulcer |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> IVC Filter | <input type="checkbox"/> Dental Problems |
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Cancer: specify _____ | | |
| <input type="checkbox"/> Hepatitis: specify _____ | | |
| <input type="checkbox"/> Other: _____ | | |

Do you have a Cardiologist: Yes No

Name of the Cardiologist: _____

Past Surgical History: Check any surgeries that you have already had.

- | | | | |
|---|---------------------------------------|--|--|
| <input type="checkbox"/> NONE | <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Gall Bladder | <input type="checkbox"/> Vascular bypass |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Tonsillectomy | <input type="checkbox"/> Fem-pop bypass |
| <input type="checkbox"/> Arthroscopic procedures: specify _____ | | | |
| <input type="checkbox"/> Fracture Repair: specify _____ | | | |
| <input type="checkbox"/> Total joint replacement: specify _____ | | | |
| <input type="checkbox"/> Back Surgery: specify _____ | | | |
| <input type="checkbox"/> Other: _____ | | | |

Medications: Use the back of this page if additional space is needed. Remember antibiotics, blood thinners, Insulin, and heart medications.

NONE

Name	Strength	Frequency	Name	Strength	Frequency

Allergies: Check all that apply.

- | | | | |
|---|-------------------------------------|-------------------------------------|---------------------------------|
| <input type="checkbox"/> NO KNOWN DRUG ALLEGIES | <input type="checkbox"/> Anesthetic | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Iodine |
| <input type="checkbox"/> Demerol | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Codeine | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Morphine | | | |
| <input type="checkbox"/> Other: _____ | | | |

WHAT APPROACH DO YOU PREFER FOR YOUR MEDICAL CARE: Natural Traditional Combination

THIS INFORMATION IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE:

Signature of the person filling out form: _____ date: _____

Doctor initial: _____

Patient: _____ Height: _____ Weight: _____ BMI: _____

Social History: Please check. Married Widowed Divorced Single

Do you smoke? yes no Packs/Day: _____ Number of years you have smoked: _____

Do you drink alcohol? yes no Drinks/Week: _____

Occupation: _____

Family History: Please check all that have significance in your family's history, not your own history.

NONE

Father has Arthritis, Diabetes, Heart disease, Stroke, Cancer. Deceased. Other: _____

Mother has Arthritis, Diabetes, Heart disease, Stroke, Cancer. Deceased. Other: _____

Siblings have Arthritis, Diabetes, Heart disease, Stroke, Cancer. Deceased. Other: _____

List family History of Blood Clots: _____

List family history of Bleeding issues: _____ Other: _____

List family history of orthopedic problems: _____

Other: _____

Review of systems: ONLY circle symptoms that apply to you. If negative circle NONE.

1. Constitutional	Night sweats	Fever/chills	NONE
	Unexpected weight loss/gain	Lbs in the last year?	
2. Eyes	Visual changes	Glasses or Contacts	NONE
3. Ears, nose, throat	Hearing problems	Sore throat	NONE
	Cold	Sinus allergies	
4. Cardiovascular	Chest Pain	Palpitations	NONE
	Leg swelling	Calf cramps with walking	
5. Respiratory	Shortness of breath	Wheezing	NONE
	Frequent cough	Coughing up blood	
6. Gastrointestinal	Ulcer	Bowel/bladder control problems	NONE
	Diarrhea	Vomiting	
7. Genitourinary	Incontinence	Burning while urinating	NONE
	Blood in urine	Kidney stones	
8. Musculoskeletal	Back ache	Joint stiffness	NONE
	Joint swelling	Joint pain	
9. Integumentary	Rash	Hair problem	NONE
	Nail problem		
10. Neurological	Headaches	Memory loss	NONE
	Fainting	Tingling and numbness	
11. Psychiatric	Depression	Nervousness	NONE
	Personality change	Previous psychiatric care	
12. Endocrine	Excessive urination	Excessive thirst	NONE
	Intolerance to heat/cold		
13. Hematologic/ Lymphatic	Abnormal bleeding	Anemia	NONE
14. Allergic/Immunologic	Immunization problems	Allergy shots	NONE

THIS INFORMATION IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE:

Signature of the person filling out form: _____ date: _____

Doctor Signature: _____

The Center for Orthopedic Surgery Problem Questionnaire

Patient: _____

Today's date: _____

Which body part is involved? _____ left right both

Check any symptoms that you are having pain swelling weakness instability numbness

Describe any others _____

When did it begin? _____ Rate your pain on a scale of 1 – 10, 10 being the worst: _____

Was it caused by an injury? yes no Was the injury job related? Yes no

Describe accident: (if applicable): _____

Is your injury due to a motor vehicle accident yes no Were you the driver passenger

Were you wearing your seatbelt? Yes no Did the airbag deploy? Yes no Attorney retained? Yes no

How did it begin? gradually suddenly Is the condition intermittent or constant?

What makes the condition worse? _____

What makes the condition better? _____

Have you had a similar problem in the past? yes no. If yes, describe: _____

Have you seen another health care provider for this problem? yes no

Doctor: _____

What specific treatment have you had?

- | | | |
|--|--|--|
| <input type="checkbox"/> NONE | <input type="checkbox"/> narcotic medication (Vicodin, Lortab) | <input type="checkbox"/> wooden soled shoe |
| <input type="checkbox"/> brace | <input type="checkbox"/> arthritis medication (Advil, Aleve) | <input type="checkbox"/> orthotics/insoles |
| <input type="checkbox"/> cast | <input type="checkbox"/> physical therapy | <input type="checkbox"/> ice or heat therapy |
| <input type="checkbox"/> cortisone injection | <input type="checkbox"/> shoe modification | <input type="checkbox"/> crutches |
| | <input type="checkbox"/> x-rays | <input type="checkbox"/> MRI |

other – describe: _____

What specific things does your condition prevent you from doing? _____

How do you exercise? _____

How far / long can you walk without stopping? (if applicable) _____ blocks, _____ miles, _____ minutes

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