

HEALTH HISTORY

Date: _____ Were you referred by a Physician? Yes ___ No ___ If yes, physician's name _____

Name: _____ Age _____ Height _____ Weight _____

Family Physician _____

Reason for seeking medical attention _____ Right Left Both

Date of injury or duration of symptoms _____ Work related? Yes ___ No ___ Are you right or left handed? _____

Have you had any diagnostic studies for this condition, such as MRI, Bone Scan, etc? Please list _____

Have you seen anyone else regarding this condition? Yes ___ No ___ If yes, list names and dates _____

Are you allergic to: (check if you are)

Latex ___ Penicillin ___ Cephalosporin ___ Mycins ___ Sulfa ___ Tetanus ___ Iodine ___ Metal ___

Dyes ___ Aspirin ___ Codeine ___ Morphine ___ Adhesive Tape ___ Arthritis Medicine ___

Foods (please list): _____

Others: _____

Please explain allergic reaction: _____

Do you currently use tobacco: _____ Cigarettes ___ Pipe ___ Smokeless ___ Amount per day: _____ Quit when? _____

Do you drink alcohol: _____ Beer ___ Liquor ___ Wine ___ Amount per day: _____ or per week: _____

What is your current occupation? _____

Have you ever been diagnosed with any of the following medical conditions:

	Yes	No		Yes	No		Yes	No
Asthma	_____	_____	Rheumatoid Arthritis.	_____	_____	Osteoarthritis	_____	_____
Kidney Disease	_____	_____	Anemia	_____	_____	Alcoholism	_____	_____
Lupus	_____	_____	Migraines	_____	_____	Sickle Cell Disease	_____	_____
Bleeding Tendencies	_____	_____	Cancer	_____	_____	Colitis	_____	_____
Heart Disease	_____	_____	Diabetes	_____	_____	Stroke	_____	_____
Epilepsy	_____	_____	Goiter	_____	_____	Stomach Ulcers	_____	_____
High Blood Pressure	_____	_____	Lung Disease	_____	_____	Depression/Anxiety	_____	_____
Polio	_____	_____	Nervous System Disorder	_____	_____	Pelvic Radiation	_____	_____
Hepatitis	_____	_____	Tuberculosis	_____	_____	COPD	_____	_____
DVT (Blood Clot)	_____	_____	Sleep Apnea	_____	_____	(Chronic Obstructive Pulmonary Disease)	_____	_____

Has anyone in your family had:

High Blood Pressure ___ Heart Disease ___ Cancer* ___ Diabetes ___ Bleeding Problems ___ Lung Disease ___ DVT (Blood Clot) ___

* If yes, what type of Cancer: _____

Other Medical Conditions: _____

Are there law suits pending on your orthopaedic condition? _____

Please list any orthopaedic surgeries and date:

Please list any other surgeries and dates:

Please list all current medications and dosages:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient Signature _____ Physician's Signature _____ Date _____

(I have reviewed this information with the patient)

Have you experienced any of the following in the last 6 months?

PLEASE ANSWER ALL QUESTIONS.

CONSTITUTIONAL

Good general health latelyNo Yes
Recent weight changeNo Yes
FeverNo Yes
FatigueNo Yes
HeadachesNo Yes

EYES

Eye disease or injuryNo Yes
Wear glasses / contact lensesNo Yes
Blurred or double visionNo Yes
GlaucomaNo Yes

ENT

Hearing lossNo Yes
Ringing in the earsNo Yes
Earaches or drainageNo Yes
Sinus problemsNo Yes
Nose bleedsNo Yes
Mouth soresNo Yes
Bleeding gumsNo Yes
Bad breath or bad tasteNo Yes
Sore throat or voice changeNo Yes
Swollen glands in neckNo Yes

CARDIOVASCULAR

Heart troubleNo Yes
Chest painsNo Yes
Sudden heart beat changesNo Yes
Swelling of feet, ankles or handsNo Yes

RESPIRATORY

Frequent coughingNo Yes
Spitting up bloodNo Yes
Shortness of breathNo Yes
Asthma or wheezingNo Yes

GASTROINTESTINAL

Loss of appetiteNo Yes
Change of bowel movementsNo Yes
Nausea or vomitingNo Yes
Frequent diarrheaNo Yes
Painful bowel movements or constipation .No Yes
Blood in stoolNo Yes
Stomach painNo Yes

GENITOURINARY

Frequent urinationNo Yes
Burning or painful urinationNo Yes
Blood in urineNo Yes
Change of force of strain when urinating No Yes
Incontinence or dribblingNo Yes
Kidney stonesNo Yes

Date

Date

Date

Date

Date

Date

Date

MUSCULOSKELETAL

Joint painNo Yes
Joint stiffness or swellingNo Yes
Weakness of muscles or jointsNo Yes
Muscle pain or crampsNo Yes
Back painNo Yes
Cold extremitiesNo Yes
Difficulty in walkingNo Yes

SKIN

Rash or itchingNo Yes
Change in skin colorNo Yes
Change in hair or nailsNo Yes
Varicose veinsNo Yes
Breast painNo Yes
Breast lumpNo Yes
Breast dischargeNo Yes

NEUROLOGICAL

Frequent or recurring headachesNo Yes
Light headed or dizzyNo Yes
Convulsions or seizuresNo Yes
Numbness or tingling sensationsNo Yes
TremorsNo Yes
ParalysisNo Yes
StrokeNo Yes

PSYCHIATRIC

Memory loss or confusionNo Yes
NervousnessNo Yes
DepressionsNo Yes
Sleep problemsNo Yes

ENDOCRINE

Glandular or hormone problemNo Yes
Thyroid diseaseNo Yes
Excessive thirst or urinationNo Yes
Heat or cold intoleranceNo Yes
Dry skinNo Yes
Change in hat or glove sizeNo Yes

HEMATOLOGIC / LYMPHATIC

Slow to heal after cutsNo Yes
Easily bruise or bleedNo Yes
AnemiaNo Yes
PhlebitisNo Yes
Past transfusionNo Yes
Enlarged glandsNo Yes

Date

Date

Date

Date

Date

Date

Patient Signature _____

Provider Signature _____