The Center for Orthopedic Surgery
Health History Questionnaire

Patient's name:_____ DOB: _____
Primary Care Physician: _____ Today's date: _____

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

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

Do you have a Cardiologist: ☐ Yes ☐ No
Name of the Cardiologist: _____

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

☐ NONE ☐ Appendectomy ☐ Gall Bladder ☐ Vascular bypass
☐ Heart Surgery ☐ Hysterectomy ☐ Tonsillectomy ☐ Fem-pop bypass
☐ Arthroscopic procedures: specify _____
☐ Fracture Repair: specify _____
☐ Total joint replacement: specify _____
☐ Back Surgery: specify _____
☐ 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.

☐ NO KNOWN DRUG ALLEGIES ☐ Anesthetic ☐ Penicillin ☐ Iodine
☐ Demerol ☐ Aspirin ☐ Codeine ☐ Sulfa
☐ Morphine
☐ 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?

☐NONE	☐narcotic medication (Vicodin, Lortab)	☐wooden soled shoe
☐brace	☐arthritis medication (Advil, Aleve)	☐orthotics/insoles
☐cast	☐physical therapy	☐ice or heat therapy
☐cortisone injection	☐shoe modification	☐crutches
	☐x-rays	☐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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Doctor initial:_____