Orthopaedic Institute, LLC

HEALTH HISTORY

Today's date: _____

Patient Name: _____ Birth date: _____

Height: _____ **Weight**: _____ Occupation: _____

History of Present Illness:

Location: _____Severity: _____
(Where is the problem?) (On a scale of 1-10 what is your pain level?)

Allergies: Penicillin Sulfa Morphine/Codeine IVP Dye NSAIDS LATEX

Other: _____

Past Medical History

MRSA	Yes	No	Bladder Infections	Yes	No
Diabetes	Yes	No	Glaucoma	Yes	No
Insulin	Yes	No	Epilepsy	Yes	No
Thyroid Disease	Yes	No	Migraine Headaches	Yes	No
Kidney Disease	Yes	No	Tuberculosis	Yes	No
Polio	Yes	No	Pneumonia	Yes	No
Hernia	Yes	No	Asthma	Yes	No
Ulcer	Yes	No	Bronchitis	Yes	No
Bleeding Disorder	Yes	No	Hives or Eczema	Yes	No
Blood Clots(DVT/PE)	Yes	No	Cancer-Type	_____	
Heart Disease	Yes	No	AIDS or HIV +	Yes	No
Stroke	Yes	No	Hepatitis-Type	_____	
High Blood Pressure	Yes	No	Osteoporosis/osteopenia	Yes	No
Low Blood Pressure	Yes	No	Any other diseases:_____		
Mitral Valve Prolapse	Yes	No	Have you ever received a Pneumonia Vaccine?	Yes	No
Anemia	Yes	No	Flu Vaccine Date: _____		
Blood/Plasma Transfusion	Yes	No	Covid 19 Vaccine Dates_____		

Surgeries:

_____

_____

_____

Medications: (Include nonprescription)

_____

_____

Patient Social History:

Marital Status: Single: ___ Married: ___ Divorced: ____ Widowed: _____
Use of alcohol: Never: ___ Rarely: ___ Moderate: ___ Daily: ___
Use of tobacco: Never: ___ Previously, but quit: _____ Current packs/day: _____
Use of drugs: Never: ___ Type/Frequency: _____

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Family Medical History:

	Age	Diseases	If Deceased, Cause of Death
Father:	_____	_____	
Mother:	_____	_____	
Siblings:	_____	_____	
	_____	_____	
	_____	_____	

Review of Systems:

Constitutional Symptoms			**Genitourinary**		
Good general health lately	Yes	No	Frequent urination	Yes	No
Recent weight changes	Yes	No	Burning or painful urination	Yes	No
Fever	Yes	No	Blood in urine	Yes	No
Fatigue	Yes	No	Incontinence or dribbling	Yes	No
Eyes			**Musculoskeletal**		
Wears glasses/contact lenses	Yes	No	Joint pain	Yes	No
Blurred or double vision	Yes	No	Joint stiffness	Yes	No
			Weakness	Yes	No
Ears /Nose/ Mouth/Throat			Muscle pains or cramps	Yes	No
Hearing loss or ringing	Yes	No	Cold extremities	Yes	No
Earaches or drainage	Yes	No			
Chronic sinus problem	Yes	No	**Integumentary**		
Nose bleeds	Yes	No	Rash or itching	Yes	No
Mouth sores	Yes	No	Change in skin color	Yes	No
Bleeding gums	Yes	No	Varicose veins	Yes	No
Cardiovascular			**Neurological**		
Heart trouble	Yes	No	Frequent or recurring headaches	Yes	No
Chest pain	Yes	No	Light headed or dizzy	Yes	No
Palpitation	Yes	No	Convulsions or seizures	Yes	No
Swelling	Yes	No	Numbness or tingling	Yes	No
			Tremors	Yes	No
Respiratory			Paralysis	Yes	No
Cough	Yes	No	Head injury	Yes	No
Spitting up blood	Yes	No			
Shortness of breath	Yes	No	**Psychiatric**		
Wheezing	Yes	No	Memory loss or confusion	Yes	No
			Depression	Yes	No
Gastrointestinal			Insomnia	Yes	No
Loss of appetite	Yes	No			
Change in bowel habits	Yes	No	**Hematologic/Lymphatic**		
Nausea or vomiting	Yes	No	Slow to heal after cuts	Yes	No
Rectal bleeding	Yes	No	Bleeding or bruising tendency	Yes	No
			Blood clots	Yes	No
			Endocrine		
			Glandular or hormone problems	Yes	No
			Excessive thirst or urination	Yes	No
			Heat or cold intolerance	Yes	No

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HEALTH HISTORY

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____

Signature of Patient, Parent or Guardian Date

Doctor's Review

_____ _____

Signature of Doctor Date

_____

Pharmacy Name and Phone Number