

PATIENT CONFIDENTIAL HEALTH HISTORY

SOUTHERN OREGON ORTHOPEDICS

Please complete this form using a black ink pen and bring with you to your appointment

Pt. ID# _____

Date : _____

Name: _____ Age: _____ Date of Birth: _____

Right or left handed? _____ Current Occupation: _____

Why are you seeing the doctor today? _____

Name of PCP(Primary Care Provider): _____ Referring Dr: _____

Result of a(n): Car Accident _____ Work Accident _____ Accident _____ Other _____

Date of Onset: _____

Past Illnesses: Please circle illnesses you have had or have now:

Diabetes type I	Diabetes type II	Stomach Ulcers	Epilepsy
Heart Disease	Eye Disease	Head Injury	Migraine
High Blood Pressure	Arthritis	Liver Disease/Hepatitis	Bowel Disease
Immuno-deficiencies	Cancer/type_____	Pneumonia	Alcoholism
Blood Clots	Thyroid Disease	Depression	Tuberculosis
Cortisone Therapy	Rheumatic Fever	Drug Abuse	Asthma
Emphysema/COPD	Kidney Disease	Gallbladder Disease	Stroke
Bleeding Problems	Radiation Tx	Sleep Apnea	Anemia
Osteoporosis	Other: _____		

<u>Past Surgeries/Hospitalizations</u>	<u>Year</u>	<u>Complications</u>

Are you presently taking anticoagulants? Yes No Describe: _____

Have you ever had general anesthesia? Yes No

Any problems with anesthesia? Yes No Describe: _____

Do you have allergy to **Latex**? Yes No

Do you have food allergies? Yes No Describe: _____

Pregnant Now (if applicable) Yes No

Allergies/Sensitivities to Medications? Yes No List: _____

<u>List All Medications</u>	<u>Dose</u>	<u>Frequency</u>	<u>Doctor</u>

List any herbal supplements or vitamins you are taking:

(Nurse only)

Height : _____ Weight : _____ Blood Pressure : _____ Pulse : _____ Temp : _____

Please Circle if You Have: Crowns Bridges Dentures Partial Loose Teeth

Hearing Aids Contact Lenses Glasses Body Piercing

Family History

Member	Alive	Deceased	Age	Health status or cause of death
Father	A	D	_____	_____
Mother	A	D	_____	_____
Sister/Brother	A	D	_____	_____
Sister/Brother	A	D	_____	_____
Sister/Brother	A	D	_____	_____
Child	A	D	_____	_____
Child	A	D	_____	_____
Child	A	D	_____	_____

Social History

Exercise ? _____ Daily _____ Weekly _____ Monthly _____ Rarely _____ Never

What type of exercise ? _____

History of substance abuse ? ___ No ___ Yes What ? _____

Do you use tobacco ? ___ No ___ Smoke ___ Chew - How much ? _____

For how many years ? _____

Do you drink alcohol ? ___ No ___ Daily ___ 1-2 x a wk ___ 1-2 x a month ___ Rarely

Review of Systems

Are you currently having or have you had problems with your:

	Circle	Describe all yes responses
Eyes	No Yes	_____
Ears, Nose, Throat	No Yes	_____
Lungs, Breathing	No Yes	_____
Heart (Chest pain, palpitations, murmur)	No Yes	_____
Digestion (Food intolerance, ulcers, pain)	No Yes	_____
Bowels (Constipation, diarrhea, ect.)	No Yes	_____
Bladder (Pain, urgency, frequency, ect,)	No Yes	_____
Appetite, weight gain/loss, weakness	No Yes	_____
Fever, chills, nausea, vomiting	No Yes	_____
Skin (rashes, sores, itching)	No Yes	_____
Excessive thirst	No Yes	_____
Balance, dizziness, numbness, tingling	No Yes	_____
Shortness of breath	No Yes	_____
Other	No Yes	_____

Patient Signature _____ Date _____

Reviewed by _____ Date _____