

**PATIENT CONFIDENTIAL HEALTH HISTORY**  
**SOUTHERN OREGON ORTHOPEDICS**

Pt. ID# \_\_\_\_\_

Date : \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Right or left handed? \_\_\_\_\_ Current Occupation: \_\_\_\_\_

Why are you seeing the doctor today? \_\_\_\_\_

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            | Anemia            | 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             |               |

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:

\_\_\_\_\_  
\_\_\_\_\_

(Nursing)

Height : \_\_\_\_\_ Weight : \_\_\_\_\_ Blood Pressure : \_\_\_\_\_ Pulse : \_\_\_\_\_ Temp : \_\_\_\_\_

**Note: Please complete this form using a black ink pen**

**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 \_\_\_\_\_

Last update 8-1-06/file/sherri o drive

**Note: Please complete this form using a black ink pen**