Health History

OrthoArizona
Arizona Orthopaedic Associates

#

Name: DOB: Age: Today's Date:

Ht_____ Wt _____ P _____ B/P _____ ☐ Right Handed ☐ Left Handed ☐ Male ☐ Female – are you or could you be pregnant? ☐ Yes ☐ No

Reason for today's visit:

Who referred you to this office?

Who is your Primary Care Physician?

Preferred Pharmacy Name: **Address:**

Phone:

Date of Injury or Onset of problem:
☐ Left Side ☐ Right Side Is this work related? ☐ No ☐ Yes→ Worker's Comp Claim Filed? ☐ No ☐ Yes

Is this related to an accident of any kind? ☐ No ☐ Yes→ ☐ Auto ☐ Other:

Do you have legal action pending regarding this? ☐ No ☐ Yes→ Attorney Name & Phone

ALLERGIES: Are you allergic to any drugs? ☐ No ☐ Yes→ list all DRUG ALLERGIES including adverse reaction

Are you allergic to?			**DRUG:**	**REACTION:**
Eggs	☐ No	☐ Yes*		
Iodine	☐ No	☐ Yes*		
Latex	☐ No	☐ Yes*		
Nuts	☐ No	☐ Yes*		
Penicillin	☐ No	☐ Yes*		
Sulfa	☐ No	☐ Yes*		
Tape	☐ No	☐ Yes*		

Note reaction to all YES answers:

CURRENT MEDICATIONS: Do you take any medication? ☐ No ☐ Yes→List all, include Over the Counter Meds, Herbs and Vitamins

Drug Name/Strength	Dose	Prescribing Physician	Drug Name/Strength	Dose	Prescribing Physician

Have you ever had a cortisone injection? ☐ No ☐ Yes→ Area injected and response to injection:

SURGICAL HISTORY: Have you undergone any surgical procedures? ☐ No ☐ Yes →List all surgeries, include right or left when indicated:

Year	Surgery	Year	Surgery

ANESTHESIA: Have you ever had any problems with anesthesia? ☐ No ☐ Yes→ Explain

Patient Name: Date:

MEDICAL HISTORY: Have you ever had problems with: (IF *"YES", please check box*)

- ❒ Allergies (Hay Fever)
- ❒ Anemia
- ❒ Arthritis
- ❒ Asthma
- ❒ Birth Defect
- ❒ Bladder
- ❒ Bleeding Disorder
- ❒ Blood Clots
- ❒ Cancer
- ❒ Depression
- ❒ Diabetes
- ❒ Emphysema
- ❒ Epilepsy or Seizures
- ❒ Fibromyalgia
- ❒ Gout
- ❒ Heart Disease
- ❒ Hepatitis/Jaundice
- ❒ High Blood Pressure
- ❒ High Cholesterol
- ❒ HIV/AIDS
- ❒ Kidneys
- ❒ Liver
- ❒ Lungs
- ❒ Mental Illness
- ❒ Migraine Headaches
- ❒ Multiple Sclerosis
- ❒ Neurological Problems
- ❒ Old Fracture
- ❒ Osteomyelitis
- ❒ Osteoporosis
- ❒ Polio
- ❒ Sickle Cell
- ❒ Sleep Apnea
- ❒ Stomach/Ulcers
- ❒ Stroke
- ❒ Thyroid Disease
- ❒ Tuberculosis
- ❒ Wound Healing
- ❒ Other

DESCRIBE ALL YES RESPONSES: _____

_____

_____

If you are over the age of 50 have you received an Influenza (Flu) shot within the last year? Yes or No Date: _____

If you are over the age of 65 have you received a Pneumonia Vaccination? Yes or No Date: _____

REVIEW OF SYSTEMS: Are you currently having problems with: (IF *"YES", please check box(s)*

GENERAL:
- ❒ Unexpected Weight Loss
- ❒ Weight Gain
- ❒ Fever
- ❒ Fatigue
- ❒ Chills
- ❒ Other: _____
  - ❒ Check box if NO to all above

LUNGS:
- ❒ Shortness of Breath
- ❒ Snoring
- ❒ Coughing
- ❒ Wheezing
- ❒ Tightness
- ❒ Other: _____
  - ❒ Check box if NO to all above

SKIN:
- ❒ Redness
- ❒ Rash
- ❒ Itching
- ❒ Poor Healing
- ❒ Skin Changes
- ❒ Other: _____
  - ❒ Check box if NO to all above

ENDOCRINE:
- ❒ Excessive Thirst
- ❒ Heat/Cold Intolerance
- ❒ Excessive Urination
- ❒ Other: _____
  - ❒ Check box if NO to all above

EYES:
- ❒ Blurred Vision
- ❒ Double Vision
- ❒ Corrective Lens
- ❒ Eye Pain
- ❒ Eye Redness
- ❒ Watering
- ❒ Other: _____
  - ❒ Check box if NO to all above

STOMACH/COLON:
- ❒ Heart Burn
- ❒ Nausea
- ❒ Vomiting
- ❒ Diarrhea
- ❒ Constipation
- ❒ Bloody/Tarry Stools
- ❒ Other: _____
  - ❒ Check box if NO to all above

NEUROLOGIC:
- ❒ Dizziness
- ❒ Tremors
- ❒ Unsteady Gait
- ❒ Seizure
- ❒ Numbness/Tingling
- ❒ Other: _____
  - ❒ Check box if NO to all above

ALLERGIC:
- ❒ Foods
- ❒ Dust
- ❒ Pollen
- ❒ Hay Fever
- ❒ Other: _____
  - ❒ Check box if NO to all above

EAR/NOSE/THROAT:
- ❒ Headache
- ❒ Nose Bleeds
- ❒ Ringing in Ears
- ❒ Earache
- ❒ Difficulty Swallowing
- ❒ Other: _____
  - ❒ Check box if NO to all above

URINARY/GENITAL:
- ❒ Frequency
- ❒ Urgency
- ❒ Bleeding
- ❒ Difficult/Painful Urination
- ❒ Other: _____
  - ❒ Check box if NO to all above

MENTAL HEALTH:
- ❒ Anxiety
- ❒ Nervousness
- ❒ Depression
- ❒ Hallucinations
- ❒ Other: _____
  - ❒ Check box if NO to all above

HEART:
- ❒ Chest Pain
- ❒ Murmurs
- ❒ Fainting
- ❒ Palpitations
- ❒ Other: _____
  - ❒ Check box if NO to all above

MUSCLE/JOINTS:
- ❒ Joint Pain
- ❒ Stiffness
- ❒ Joint Swelling
- ❒ Joint Instability
- ❒ Redness
- ❒ Heat
- ❒ Muscle Pain
- ❒ Other: _____
  - ❒ Check box if NO to all above

BLOOD:
- ❒ Easy Bleeding
- ❒ Bruising
- ❒ Other: _____
  - ❒ Check box if NO to all above

DESCRIBE ALL YES RESPONSES:

_____

_____

_____

Patient Name: _____ Date: _____

FAMILY HISTORY:

	None	Mother	Father	Siblings		None	Mother	Father	Siblings
Asthma	❒	❒	❒	❒	Mental Illness	❒	❒	❒	❒
Bleeding Disorders	❒	❒	❒	❒	Osteoarthritis	❒	❒	❒	❒
Cancer	❒	❒	❒	❒	Rheumatoid Arthritis	❒	❒	❒	❒
Diabetes	❒	❒	❒	❒	Seizures	❒	❒	❒	❒
DVT (Blood Clots)	❒	❒	❒	❒	Sickle Cell	❒	❒	❒	❒
Heart Disease	❒	❒	❒	❒	Stroke	❒	❒	❒	❒
High Blood Pressure	❒	❒	❒	❒	Thyroid Disease	❒	❒	❒	❒
Kidney Disease	❒	❒	❒	❒	Other	❒	❒	❒	❒

Give Details to "Other" and any positive responses:

_____

_____

SOCIAL HISTORY:

Do you smoke tobacco? ❒ No ❒ Yes→ _____ packs per day for _____ years

Did quit smoking tobacco? ❒ No ❒ Yes→ When did you quit?_____ Previous smoked_____ packs per day for _____ years

Do you chew tobacco? ❒ No ❒ Yes→ How Often?_____

Do you drink alcohol? ❒ No ❒ Yes→ How Much and How Often _____

Do you live alone? ❒ No ❒ Yes Do you have children? ❒ No ❒ Yes→ Number of Children _____

Do you use walking aids? ❒ No ❒ Yes→ ❒ Cane ❒ Crutches ❒ Walker ❒ Other _____

Do you have a history of substance abuse or do you use recreational drugs? ❒ No ❒ Yes→ If "Yes" explain _____

Do you exercise? ❒ Never ❒ Rarely ❒ Weekly ❒ Daily Type _____

Marital Status: ❒ Single ❒ Married ❒ Widowed ❒ Divorced ❒ Current Occupation: _____
(or occupation prior to retirement)

Patient Signature _____ Date _____

If a minor Parent or Guardian Signature _____ Date _____

Reviewed by _____ Date _____

MD/PA Signature _____ Date _____

PHYSICIAN NOTES: