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| **ORTHO PATIENT HEALTH HISTORY FORM****PLEASE COMPLETE IN BLACK INK** | TODAY’S DATE PAGE 3 |
| LAST NAME | LEGAL FIRST NAME | MI | DATE OF BIRTH |
| **REVIEW OF SYSTEMS****PLEASE CHECK ALL ITEMS EITHER NO OR YES** |
| **ORTHOPEDIC** | **No** | **Yes** | **HEMATOLOGY** | **No** | **Yes** | **PERIPHERAL VASCULAR** | **No** | **Yes** |
| History of Fracture(s) |  |  | Bleeding Disorders |  |  | Do you see a Vascular Physician |  |  |
|  If Yes, Which Bone(s) | On a blood thinner |  |  |
|  If Yes, When | History of Deep Vein Thrombosis |  |  |  If Yes, Who |
| History of a Dexa Scan |  |  | History of MRSA |  |  |
|  If Yes, When | History of Pulmonary Embolism |  |  | Dry Skin |  |  |
| **GENERAL/CONSTITUTION** | **No** | **Yes** | Eczema |  |  |
| Chills |  |  | Family History of Clotting Disorder |  |  | Rash |  |  |
| Fatigue |  |  | **NEUROLOGIC** | **No** | **Yes** |
| Fever |  |  | Easy Bruising |  |  | Balance Difficulty |  |  |
| Weight Gain |  |  | Prolonged Bleeding |  |  | Coordination Problems |  |  |
| Weight Loss |  |  | Recent Transfusion |  |  | Difficulty Walking |  |  |
| **EAR/NOSE/THROAT** | **No** | **Yes** | **WOMEN ONLY** | **No** | **Yes** | Tingling |  |  |
| Glasses or Contacts |  |  | X-ray may be taken; do you think you are pregnant |  |  | **PSYCHIATRIC** | **No** | **Yes** |
| Dentures |  |  | Anxiety |  |  |
| Decreased Hearing |  |  | **MUSCULOSKELETAL** | **No** | **Yes** | Depressed Mood |  |  |
| **RESPIRATORY** | **No** | **Yes** | Numbness |  |  | Difficulty Sleeping |  |  |
| Cough |  |  | Joint Stiffness |  |  |  |  |  |
| Shortness of Breath |  |  | Leg Cramps |  |  | **ALLERGIES** | **No** | **Yes** |
| Wheezing |  |  | Muscle Aches |  |  | Aspirin |  |  |
| **CARDIOVASCULAR** | **No** | **Yes** | Back Pain |  |  | Codeine |  |  |
| Chest Pain |  |  | Neck Pain |  |  | Latex |  |  |
| Do you see a Cardiologist |  |  | Sciatica |  |  | Penicillin |  |  |
|  If yes, Who | Swollen Joints |  |  | Shellfish |  |  |
| **GASTROINTESTINAL** | **No** | **Yes** | Trauma to Ankle(s) |  |  | Sulfa |  |  |
| Exposure to Hepatitis |  |  | Trauma to Arm(s) |  |  | Other: |  |  |
|  |  |  | Trauma to Hip(s) |  |  | What was your reaction |
|  |  |  | Trauma to Knee(s) |  |  |
|  |  |  | Weakness |  |  |
| **HOSPITALIZATIONS** **(NOT INCLUDING NORMAL PREGNANCIES)** | **SERIOUS ILLNESS** **(NOT REQUIRING HOSPITALIZATION)** |
|  | Year |  | Year |
|  | Year |  | Year |
|  | Year |  | Year |
|  | Year |  | Year |
| **PAST SURGERIES** | **PAST ACCIDENTS** |
|  | Year |  | Year |
|  | Year |  | Year |
|  | Year |  | Year |
|  | Year |  | Year |
| **ANESTHESIA** |
|  | **No** | **Yes** |  |
| Have you ever had anesthesia? |  |  |  |
| If yes, Did you have an problems? |  |  |  |
| If yes, What kind of problems? |

The information on this form is correct to the best of my knowledge.

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 PATIENT/AUTHORIZED REPRESENTATIVE SIGNATURE DATE REVIEWED BY PROVIDER DATE