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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