ProOrtho
ORTHOPEDICS & SPORTS MEDICINE
Personalized care. Optimal results.

Patient Health History Form

Phone: (425) 823 - 4000 Fax: (425) 821 - 3550

Patient Label:

Male: ◯ Female: ◯ (Pregnant: No ◯ Yes ◯ Unsure ◯

Height: _____ Weight: _____

Office Use: BP:_____ HR:_____

Referring Physician: _____

Primary Care Physician: _____

What are you being seen for today? _____

ALLERGIES

◯ I have no allergies to medication.

Medication	Reaction	Medication	Reaction
1) _____	_____	4) _____	_____
2) _____	_____	5) _____	_____
3) _____	_____	6) _____	_____

Latex allergy? ◯ No ◯ Yes

Food allergy? ◯ No ◯ Yes, type_____

Please list below any pain medications you do not tolerate.

_____

MEDICATIONS

Please list ALL medications and doses that you are CURRENTLY taking (this includes birth control pills, hormones, IUDs, vitamins and herbal supplements):

Medication	Dose/ Strength	# Pills per Day	Reason
1) _____	_____	_____	_____
2) _____	_____	_____	_____
3) _____	_____	_____	_____
4) _____	_____	_____	_____
5) _____	_____	_____	_____
6) _____	_____	_____	_____
7) _____	_____	_____	_____
8) _____	_____	_____	_____
9) _____	_____	_____	_____
10) _____	_____	_____	_____

Have you ever had history of anemia or blood disorder? ◯ No ◯ Yes, explain_____

Have you or any relatives had problems with anesthesia? ◯ No ◯ Yes, explain _____

Have you ever had an EKG? ◯ No ◯ Yes, when/ where? _____

Do you get shortness of breath when climbing more than 2 flights of stairs? ◯ No ◯ Yes

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Patient Label:

PAST SURGICAL HISTORY

Please list the surgical procedures you have undergone:

Date of Surgery	Type of Surgery	Describe the Recovery
1)		
2)		
3)		
4)		
5)		
6)		
7)		

PAST MEDICAL HISTORY

	Explain		Explain
☐ Anemia		☐ Kidney/ bladder infections	
☐ Arthritis (“wear and tear”)		☐ Kidney stones	
☐ Asthma		☐ Kidney problems, other	
☐ Bleeding problems		☐ Liver problems	
☐ Blood clots		☐ Lupus	
☐ Cancer		☐ MRSA	
☐ COPD/ Emphysema		☐ Osteoporosis or osteopenia	
☐ Depression		☐ Prostate problems	
☐ Diabetes		☐ Psychiatric problems	
☐ Drug or alcohol problems		☐ Rheumatoid arthritis	
☐ GERD / reflux		☐ Scoliosis	
☐ Gout		☐ Seizures	
☐ Hearing problems		☐ Stroke	
☐ Heart attack		☐ Thyroid problems	
☐ Heart disease		☐ Tuberculosis	
☐ Hepatitis		☐ Ulcerative colitis/ Crohn’s	
☐ High blood pressure		☐ Ulcers	
☐ HIV positive/ AIDS		☐ Other:	

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Patient Label:

FAMILY HISTORY: *Please check any conditions associated with your immediate family members*

	Mother	Father	Son	Daughter	Brother	Sister	Other
Anesthesia Problems							
Arthritis							
Back Pain							
Cancer: _____							
Clotting Disorder							
COPD/Emphysema							
Diabetes							
Drug Addiction							
Alcohol Addiction							

	Mother	Father	Son	Daughter	Brother	Sister	Other
Heart Disease							
High Blood Pressure/Hypertension							
Malignant Hyperthermia							
Osteoporosis / Osteopenia							
Rheumatoid Arthritis							
Sleep Apnea							
Stroke							
Other: _____							
Other: _____							

SOCIAL HISTORY

Do you use tobacco products?

- ◯ Yes, I smoke_____packs per day
- ◯ Yes, I currently chew tobacco/ snuff
- ◯ No, I quit smoking/ chewing _____years_____months ago
- ◯ No, I have never used tobacco products

Current situation?

- ◯ Married
- ◯ Divorced
- ◯ Single
- ◯ Widowed
- ◯ Separated
- ◯ Living with significant other

Do you consume alcoholic beverages (e.g., beer, wine, liquor)?

◯ No ◯ Yes, type: _____amount/ week: _____

Do you use illicit drugs? ◯ No ◯ Yes, type: _____

Do you have children?

◯ No ◯ Yes, how many? _____

Do you live: ◯ alone ◯ with spouse, family, and/ or friend(s) ◯ assisted living

Have you had a recent change in a significant relationship in the last year or other stress? ◯ No ◯ Yes

If yes, please explain: _____

WORK HISTORY

What is your occupation or previous one if currently not working?_____

Briefly describe your job:_____

Name of employer:_____ **Last date worked:**_____

Please mark ONE statement that best describes your current employment situation:

- ◯ currently working
- ◯ on paid leave
- ◯ on unpaid leave
- ◯ unemployed
- ◯ student
- ◯ homemaker
- ◯ disabled/ retired from an orthopedic and/or spine problem
- ◯ disabled/ retired from a health problem (NOT from an orthopedic or spine problem)
- ◯ retired (not due to health)
- ◯ other, please specify_____

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Patient Label:

REVIEW OF SYSTEMS

Please mark the circle next to ANY symptoms you have experienced in the past 6 months:

Constitution	Eyes	Gastrointestinal	Other
☐ Fever	☐ Blurred Vision	☐ Heartburn	☐ Easy Bruise/Bleed
☐ Chills	☐ Double Vision	☐ Nausea	☐ Environmental Allergies
☐ Weight Loss	☐ Sensitivity to Light	☐ Vomiting	☐ Other _____
☐ Malaise/Fatigue	☐ Eye Pain	☐ Abdominal Pain	
☐ Sweating	☐ Eye Discharge	☐ Diarrhea	**Neurological**
☐ Weakness	☐ Eye Redness	☐ Constipation	☐ Dizziness
☐ Other _____	☐ Other _____	☐ Blood in Stool	☐ Headaches
		☐ Melena	☐ Tingling
Skin	**Cardiovascular**	☐ Other _____	☐ Tremor
☐ Rash	☐ Chest Pain		☐ Sensory Change
☐ Itching	☐ Palpitations	**Genitourinary**	☐ Speech Change
☐ Other _____	☐ Shortness of Breath	☐ Painful Urination	☐ Focal Weakness
	☐ Leg Cramps	☐ Urgency of Urination	☐ Seizures
HENT	☐ Leg Swelling	☐ Frequency of Urination	☐ Loss of Consciousness
☐ Hearing Loss	☐ Sleep Apnea	☐ Blood in Urine	☐ Other _____
☐ Ringing in Ears	☐ Other _____	☐ Flank Pain	
☐ Ear Pain		☐ Other _____	**Mental Health**
☐ Ear Discharge	**Respiratory**		☐ Depression
☐ Nosebleeds	☐ Coughs	**Musculoskeletal**	☐ Suicidal Ideas
☐ Congestion	☐ Coughing up Blood	☐ Muscle Pain	☐ Substance Abuse
☐ Sinus Pain	☐ Sputum Production	☐ Neck Pain	☐ Hallucinations
☐ Stridor	☐ Shortness of Breath	☐ Back Pain	☐ Nervous/Anxious
☐ Sore Throat	☐ Wheezing	☐ Joint Pain	☐ Insomnia
☐ Excessive Thirst	☐ Other _____	☐ Falls	☐ Memory Loss
☐ Other _____		☐ Other _____	○ Other _____

○ I have not had ANY of the above symptoms in the last 6 months.

SIGNATURE

Patient's signature: _____ Date: _____

Please print name: _____

Physician's signature: _____ Date: _____

Please print name: _____