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
History of Fracture(s)		
If Yes, Which Bone(s)		
If Yes, When		
History of a Dexa Scan		
If Yes, When		
GENERAL/CONSTITUTION	**No**	**Yes**
Chills		
Fatigue		
Fever		
Weight Gain		
Weight Loss		
EAR/NOSE/THROAT	**No**	**Yes**
Glasses or Contacts		
Dentures		
Decreased Hearing		
RESPIRATORY	**No**	**Yes**
Cough		
Shortness of Breath		
Wheezing		
CARDIOVASCULAR	**No**	**Yes**
Chest Pain		
Do you see a Cardiologist		
If yes, Who		
GASTROINTESTINAL	**No**	**Yes**
Exposure to Hepatitis		

HEMATOLOGY	No	Yes
Bleeding Disorders		
On a blood thinner		
History of Deep Vein Thrombosis		
History of Pulmonary Embolism		
Family History of Clotting Disorder		
Easy Bruising		
Prolonged Bleeding		
Recent Transfusion		
WOMEN ONLY	**No**	**Yes**
X-ray may be taken; do you think you are pregnant		
MUSCULOSKELETAL	**No**	**Yes**
Numbness		
Joint Stiffness		
Leg Cramps		
Muscle Aches		
Back Pain		
Neck Pain		
Sciatica		
Swollen Joints		
Trauma to Ankle(s)		
Trauma to Arm(s)		
Trauma to Hip(s)		
Trauma to Knee(s)		
Weakness		

PERIPHERAL VASCULAR	No	Yes
Do you see a Vascular Physician		
If Yes, Who		
History of MRSA		
Dry Skin		
Eczema		
Rash		
NEUROLOGIC	**No**	**Yes**
Balance Difficulty		
Coordination Problems		
Difficulty Walking		
Tingling		
PSYCHIATRIC	**No**	**Yes**
Anxiety		
Depressed Mood		
Difficulty Sleeping		
ALLERGIES	**No**	**Yes**
Aspirin		
Codeine		
Latex		
Penicillin		
Shellfish		
Sulfa		
Other:		
What was your reaction		

HOSPITALIZATIONS (NOT INCLUDING NORMAL PREGNANCIES)	
	Year
	Year
	Year
	Year

SERIOUS ILLNESS (NOT REQUIRING HOSPITALIZATION)	
	Year
	Year
	Year
	Year

PAST SURGERIES	
	Year
	Year
	Year
	Year

PAST ACCIDENTS	
	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.

X_____

PATIENT/AUTHORIZED REPRESENTATIVE SIGNATURE DATE

_____

REVIEWED BY PROVIDER DATE