Health History

ARIZONA ORTHOPAEDIC ASSOCIATES
A T G A T E W A Y

#

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?

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: ______________________________

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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:

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POS® Reorder # 0413986

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:

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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 ______________________

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Do you exercise? ☐ Never ☐ Rarely ☐ Weekly ☐ Daily Type ______________________

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

Patient/Guardian Signature ______________________________Date ____________

Reviewed by ______________________________Date ____________

MD Signature______________________________Date ____________

PHYSICIAN NOTES:

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