

# Health History



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

#

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_  Right Handed  Male  
 Left Handed  Female – are you or could you be pregnant?  No  Yes

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 <input type="checkbox"/> No <input type="checkbox"/> Yes*	_____	_____
Iodine <input type="checkbox"/> No <input type="checkbox"/> Yes*	_____	_____
<b>Latex</b> <input type="checkbox"/> No <input type="checkbox"/> Yes*	_____	_____
Nuts <input type="checkbox"/> No <input type="checkbox"/> Yes*	_____	_____
Penicillin <input type="checkbox"/> No <input type="checkbox"/> Yes*	_____	_____
Sulfa <input type="checkbox"/> No <input type="checkbox"/> Yes*	_____	_____
Tape <input type="checkbox"/> No <input type="checkbox"/> 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)

- |  |   |  |  |  |
|--|---|--|--|--|
| <input type="checkbox"/> Allergies (Hay Fever) | <input type="checkbox"/> Cancer               | <input type="checkbox"/> Hepatitis/Jaundice  | <input type="checkbox"/> Migraine Headaches    | <input type="checkbox"/> Sleep Apnea     |
| <input type="checkbox"/> Anemia                | <input type="checkbox"/> Depression           | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Multiple Sclerosis    | <input type="checkbox"/> Stomach/Ulcers  |
| <input type="checkbox"/> Arthritis             | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> Neurological Problems | <input type="checkbox"/> Stroke          |
| <input type="checkbox"/> Asthma                | <input type="checkbox"/> Emphysema            | <input type="checkbox"/> HIV/AIDS            | <input type="checkbox"/> Old Fracture          | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Birth Defect          | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Kidneys             | <input type="checkbox"/> Osteomyelitis         | <input type="checkbox"/> Tuberculosis    |
| <input type="checkbox"/> Bladder               | <input type="checkbox"/> Fibromyalgia         | <input type="checkbox"/> Liver               | <input type="checkbox"/> Osteoporosis          | <input type="checkbox"/> Wound Healing   |
| <input type="checkbox"/> Bleeding Disorder     | <input type="checkbox"/> Gout                 | <input type="checkbox"/> Lungs               | <input type="checkbox"/> Polio                 | <input type="checkbox"/> Other           |
| <input type="checkbox"/> Blood Clots           | <input type="checkbox"/> Heart Disease        | <input type="checkbox"/> Mental Illness      | <input type="checkbox"/> Sickle Cell           |  |

**DESCRIBE ALL YES RESPONSES:** \_\_\_\_\_

**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

**EYES:**

- Blurred Vision
- Double Vision
- Corrective Lens
- Eye Pain
- Eye Redness
- Watering
- Other: \_\_\_\_\_
- Check box if NO to all above

**ALLERGIC:**

- Foods
- Dust
- Pollen
- Hay Fever
- Other: \_\_\_\_\_
- Check box if NO to all above

**HEART:**

- Chest Pain
- Murmurs
- Fainting
- Palpitations
- Other: \_\_\_\_\_
- Check box if NO to all above

**LUNGS:**

- Shortness of Breath
- Snoring
- Coughing
- Wheezing
- Tightness
- 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

**EAR/NOSE/THROAT:**

- Headache
- Nose Bleeds
- Ringing in Ears
- Earache
- Difficulty Swallowing
- 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

**SKIN:**

- Redness
- Rash
- Itching
- Poor Healing
- Skin Changes
- Other: \_\_\_\_\_
- Check box if NO to all above

**NEUROLOGIC:**

- Dizziness
- Tremors
- Unsteady Gait
- Seizure
- Numbness/Tingling
- Other: \_\_\_\_\_
- Check box if NO to all above

**URINARY/GENITAL:**

- Frequency
- Urgency
- Bleeding
- Difficult/Painful Urination
- Other: \_\_\_\_\_
- Check box if NO to all above

**BLOOD:**

- Easy Bleeding
- Bruising
- Other: \_\_\_\_\_
- Check box if NO to all above

**MENTAL HEALTH:**

- Anxiety
- Nervousness
- Depression
- Hallucinations
- Other: \_\_\_\_\_
- Check box if NO to all above

**ENDOCRINE:**

- Excessive Thirst
- Heat/Cold Intolerance
- Excessive Urination
- Other: \_\_\_\_\_
- Check box if NO to all above

**DESCRIBE ALL YES RESPONSES:** \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

<b>FAMILY HISTORY:</b>	None	Mother	Father	Siblings		None	Mother	Father	Siblings
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DVT (Blood Clots)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Give Details to "Other" and any positive responses:

**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 \_\_\_\_\_

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:**
