323 E. Town St. 1St Floor
Columbus, OH 43215
Grant PAT Clinic
614-566-9471

Patient Health History

This information is very important in your care. Please complete as carefully and accurately as possible.

Name: _____ Date: _____

Height: _____ inches Weight: _____ lbs Age: _____

Symptoms:

1. Type of symptoms related to your visit: ☐ Pain ☐ Instability ☐ Infection
2. Other symptoms: _____
3. Location of symptoms: ☐ Right Hip ☐ Left Hip ☐ Right Knee ☐ Left Knee
   ☐ Right Shoulder ☐ Left Shoulder ☐ Back
   Other: _____
4. Severity of symptoms: ☐ Mild ☐ Moderate ☐ Severe
   ☐ Constant ☐ Intermittent ☐ With Activity
5. Duration of symptoms: Days: _____Weeks: _____ Months: _____ Years: _____

Please list all prior surgeries OR ☐ No previous surgeries

Type of surgery including **Side/Area**	Estimated Year
A. _____	_____
B. _____	_____
C. _____	_____
D. _____	_____
E. _____	_____
F. _____	_____
G. _____	_____

6. **Prior Hospitalizations other than surgery** **OR** ☐ **No previous hospitalizations**

Reason for Hospitalization: Estimated Year

A. _____ _____

B. _____ _____

C. _____ _____

D. _____ _____

7. **Medical Illnesses** for which you are currently being treated for (i.e. high blood pressure, diabetes, heart disease, etc.) **Please list on the next page (9) the name of the medication that you take for this condition**.

☐ **NONE**

Condition: Estimated year at onset

A. _____ _____

B. _____ _____

C. _____ _____

D. _____ _____

E. _____ _____

F. _____ _____

G. _____ _____

H. _____ _____

8. **Medication Allergies** or Sensitivities (example: Penicillin causes rash) OR ☐ **NONE (NO KNOWN ALLERGIES)**

Name of Medication Reaction

A. _____ _____

B. _____ _____

C. _____ _____

D. _____ _____

9. **Metal Allergies** or Sensitivities (example: rash or blistering with any type of jewelry or metal-framed eyeglasses)

☐ **No known metal allergies**

☐ **Metal allergies**

☐ Aluminum

☐ Nickel

☐ Other _____

☐ Other _____

☐ Other _____

Additional Notes_____

_____

_____

10. List **All Current Medications** you are now taking or have taken in the last two weeks; **including over the counter medications, herbal medications, inhalers, breathing machines, and/or oxygen, eye drops and topicals/ patches.**

Medication name	Strength or dosage	Time of day taken (AM, PM, bedtime)	Number of pills taken each time	Reason for use
Example: Lipitor	*20 mg*	*Bedtime*	*One*	*High cholesterol*

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Medication name	Strength or dosage	Time of day taken (AM, PM, bedtime)	Number of pills taken each time	Reason for use

11. Have you ever received a blood transfusion in the past? Yes ☐ No ☐
If yes, did you have an adverse reaction to the blood transfusion?

_____

12. Do you have any religious beliefs against receiving blood? Yes ☐ No ☐

13. Have you ever had difficulty with anesthesia? Yes ☐ No ☐
If yes, please explain

_____

14. Do you have any bleeding tendencies? (Example: bloody urine, bloody stools) Yes ☐ No ☐
If yes, please explain _____

15. Have any of your primary/direct **family** members (mother, father, brother, sister) had any of the following:
NOT yourself --your family member

☐ **Unknown**

Blood clots in the legs or lungs	Yes ☐	No ☐
Surgical complications	Yes ☐	No ☐
Difficulty with anesthesia	Yes ☐	No ☐
Heart disease (heart attack, angina, or chest pain) — prior to age 60	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐
Bleeding tendencies or disorders	Yes ☐	No ☐

If you answered yes to any of the questions about your family history in number 15, please explain:

_____

_____

_____

16. Do you currently smoke or chew tobacco products? Yes ☐ No ☐
If yes, year you started? _____ Number of packs per day at most were you smoking? _____
Have you ever been a smoker in the past? Yes ☐ No ☐
How many years did you smoke? _____ If you quit smoking, what year did you quit? _____
Never used tobacco products ☐

17. Do you currently drink alcohol? Yes ☐ No ☐ Never ☐
Number of drinks per day _____ Number of drinks per week _____
Number of years of alcohol use _____
Have you had any medical complications from alcohol Yes ☐ No ☐
Have you had any withdrawal symptoms when not drinking? Yes ☐ No ☐

18. Do you have any history of substance abuse or drug addiction? Yes ☐ No ☐

Review of Systems: Do you have a personal history of the following?

19. **General**

Recent unexplained weight loss	Yes ☐ No ☐
Recent unexplained weight gain	Yes ☐ No ☐
Recent unexplained fevers or chills	Yes ☐ No ☐
Any recent infections?	Yes ☐ No ☐
Do you exercise?	Yes ☐ No ☐

If yes, how long and how often? _____

HEENT

Glasses	Yes ☐ No ☐
Cataracts	Yes ☐ No ☐
Glaucoma	Yes ☐ No ☐
Hearing loss or wear hearing aids	Yes ☐ No ☐
Dentures or partials Upper ☐ Lower ☐ Both ☐	Yes ☐ No ☐
Active dental infection or tooth pain	Yes ☐ No ☐

Cardiac

High blood pressure	Yes ☐ No ☐
Heart attack	Yes ☐ No ☐
Congestive heart failure	Yes ☐ No ☐
Heart valve replacement	Yes ☐ No ☐
Open-heart surgery for bypass	Yes ☐ No ☐
Did your heart doctor balloon open any of your heart arteries?	Yes ☐ No ☐
Did your heart doctor stent any of your heart arteries?	Yes ☐ No ☐
Do you have chest pain with exertion?	Yes ☐ No ☐
Do you have swelling in your legs?	Yes ☐ No ☐
Have you ever been told that you have a heart murmur?	Yes ☐ No ☐
Do you have palpitations or rhythm disturbances?	Yes ☐ No ☐

Heart Tests

Have you ever had a cardiac stress test?	Yes ☐ No ☐
Heart catheterization/ angiogram	Yes ☐ No ☐
Echocardiogram (an ultrasound of your heart)	Yes ☐ No ☐

If you answered yes, please state what year and the name of where you had the test performed:

_____

_____

Name of Cardiologist (if applies) _____

Date of last visit _____

Pulmonary

Asthma, COPD, emphysema, or chronic bronchitis? Yes ☐ No ☐
Do you experience shortness of breath with exertion? Yes ☐ No ☐
Need to sleep propped up on 2 or more pillows due to breathing? Yes ☐ No ☐
Do you wake up at night with shortness of breath? Yes ☐ No ☐
Have you ever required treatment with oxygen at home? Yes ☐ No ☐
Do you have sleep apnea? Yes ☐ No ☐
If yes, do you use C-PAP ☐ or Bi-PAP ☐
Have you ever tested positive for tuberculosis (TB)? Yes ☐ No ☐
Do you have seasonal allergies or hay fever? Yes ☐ No ☐

GI

Frequent diarrhea Yes ☐ No ☐
Frequent constipation Yes ☐ No ☐
Diverticulitis Yes ☐ No ☐
Irritable bowel syndrome Yes ☐ No ☐
Crohn's disease Yes ☐ No ☐
Ever had part of your colon removed or an intestinal surgery? Yes ☐ No ☐
Peptic ulcer disease/Duodenal ulcer Yes ☐ No ☐
Intestinal bleeding Yes ☐ No ☐
Difficulty with swallowing Yes ☐ No ☐
Heartburn or gastro-esophageal reflux disease Yes ☐ No ☐
Abdominal pain Yes ☐ No ☐
History of severe post-operative constipation/ileus Yes ☐ No ☐
Liver disease or cirrhosis Yes ☐ No ☐
Date of last Colonoscopy/Endoscopy _____

Genitourinary

Current burning or pain with urination? Yes ☐ No ☐
Have you had a bladder infection/urinary infection in past 6 months or more than 3 in the past year? Yes ☐ No ☐

Prostate enlargement (if you're a man) Yes ☐ No ☐
Have you ever donated a kidney or had one removed? Yes ☐ No ☐
Kidney stones Yes ☐ No ☐
Have you ever been told that your kidneys weren't working as well as they should or that you have Chronic Kidney Disease? Yes ☐ No ☐
Receiving dialysis? Yes ☐ No ☐
If so who is your kidney doctor? _____

Where do you go for dialysis? _____

What days do you receive dialysis? _____

Have you had trouble urinating after surgery or trouble in the past with urinary catheter insertion? Yes ☐ No ☐

Musculoskeletal

Have you ever been told that you have Rheumatoid Arthritis? Yes ☐ No ☐
Have you ever been told that you have Osteoporosis? Yes ☐ No ☐

Neurologic

Stroke or TIA (mini stroke) Yes ☐ No ☐
Paralysis or temporary loss of strength, sensation, or vision Yes ☐ No ☐
Were you ever told that you are legally blind? Yes ☐ No ☐
Frequent fainting spells or dizziness Yes ☐ No ☐
Seizures Yes ☐ No ☐
Frequent headaches or migraine headaches Yes ☐ No ☐
Chronic neck or back pain Yes ☐ No ☐
Chronic pain syndrome Yes ☐ No ☐

Emotion/Mood

Confusion or disorientation after surgery Yes ☐ No ☐
Anxiety for which you are being treated or are taking medicines Yes ☐ No ☐
Depression for which you are being treated or are taking medicines Yes ☐ No ☐
Any other emotional problems Yes ☐ No ☐

Endocrine

High cholesterol Yes ☐ No ☐
Thyroid problems (underactive or overactive thyroid) Yes ☐ No ☐
Diabetes (this includes being borderline) Yes ☐ No ☐
Have you ever been in DKA (diabetic ketoacidosis)? Yes ☐ No ☐

If Diabetic HgBA1c (date/level) _____

Typical AM fasting blood sugar _____

Have you used steroids either as a pill or injection in the last month? Yes ☐ No ☐

Vascular

Blood clots in your legs/lungs (DVT, phlebitis, pulmonary embolism) Yes ☐ No ☐

If yes, what was your treatment and for how long? _____

Aneurysm, if yes where _____ Yes ☐ No ☐

Have you ever had surgery on any of your arteries? Yes ☐ No ☐
(This includes stent, balloon procedure, or bypass of the leg arteries)

If yes, where was your surgery? _____

Do you have pain in the legs, buttocks or calves with walking? Yes ☐ No ☐

Other

Anemia or Low Blood Count Yes ☐ No ☐
Elevated White Blood Cell Count Yes ☐ No ☐

Unusual or frequent infections	Yes ☐ No ☐
Poor wound healing	Yes ☐ No ☐
Current open wound	Yes ☐ No ☐
Pressure ulcers/ bed sores	Yes ☐ No ☐
Currently pregnant or have been in the last 3 months	Yes ☐ No ☐
If you're a woman, have you gone through menopause?	Yes ☐ No ☐
Do you take hormone replacement therapy or birth control?	Yes ☐ No ☐

Have you ever had cancer of any kind? Yes ☐ No ☐

If you answered yes, where was/is the cancer? _____

What was/is your treatment? _____

Who was/is your cancer doctor? _____

Have you ever had an organ transplant? Yes ☐ No ☐

If yes, when and what organ? _____

Who is the doctor that follows your progress? _____

If you have answered yes to any of the above-mentioned questions please explain:

_____

_____

_____

_____

Form completed by: _____ Date: _____

If other than the patient, please identify the relationship: _____

Reviewed by: _____ Date: _____