

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 <u>Side/Area</u>	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
<i>Example: Lipitor</i>	<i>20 mg</i>	<i>Bedtime</i>	<i>One</i>	<i>High cholesterol</i>

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 <input type="checkbox"/>	No <input type="checkbox"/>
Surgical complications	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Difficulty with anesthesia	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Heart disease (heart attack, angina, or chest pain) — prior to age 60	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Bleeding tendencies or disorders	Yes <input type="checkbox"/>	No <input type="checkbox"/>

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
- 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: _____

7277 Smiths Mill Rd
#250
New Albany, OH 43054

General Medical Consultants, Inc.

614-221-3725