Bone & Joint Specialist

Health History

Name: ____________ Age: ____________ Date of Birth: ____________

Were you referred by a physician? Yes ❐ No ❐ If yes, Name of Physician: ____________

Reason for seeking medical attention: ____________

Which extremity are we seeing you for? Right ❐ Left ❐ Both ❐ Are you right or left handed? ____________

Date of injury or duration of symptoms: ____________ Work related? Yes ❐ No ❐

What is your current occupation? ____________ Who is your employer? ____________

Have you had any diagnostic studies for this condition? X-Rays ❐ MRI ❐ Bone Scan ❐ CT Scan ❐ Other ____________

Have you ever been diagnosed with any of the following medical conditions?

	Yes	No		Yes	No		Yes	No
Asthma	❐	❐	Rheumatoid Arthritis	❐	❐	Osteoarthritis	❐	❐
Kidney Disease	❐	❐	Anemia	❐	❐	Alcoholism	❐	❐
Lupus	❐	❐	Migraines	❐	❐	Sickle Cell Disease	❐	❐
Bleeding Tendencies	❐	❐	Cancer	❐	❐	Colitis	❐	❐
Heart Disease	❐	❐	Diabetes	❐	❐	Stroke	❐	❐
Epilepsy	❐	❐	Goiter	❐	❐	Stomach Ulcers	❐	❐
High Blood pressure	❐	❐	Lung Disease	❐	❐	Depression/Anxiety	❐	❐
Polio	❐	❐	Nervous System Disorder	❐	❐	COPD	❐	❐
Hepatitis	❐	❐	Tuberculosis	❐	❐	(Chronic Obstructive Pulmonary Disease)		

List *ORTHOPAEDIC* surgeries you have had & dates:

____

____

____

List any other surgeries you have had & dates:

____

____

____

List CURRENT medications you take and dosage:

____

____

____

____

____

List any MEDICINE ALLERGIES you have:

____

Tobacco use: Cigarettes ❐ Pipe ❐ Smokeless ❐ Non-Smoker ❐ Amount per day: ________ Quit when? ________

Alcohol use: Amount per day: ________ Per week: ________ Per month: ________

Has anyone in your family had any of the following health conditions?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	❐	❐	Diabetes	❐	❐	Lung Disease	❐	❐
Heart Disease	❐	❐	Bleeding Problems	❐	❐	Other: ________	❐	❐
Cancer	❐	❐	*If yes, what type of cancer? ____________					

Have you recently had any of the following problems or symptoms?

	Yes	No		Yes	No		Yes	No
Chest Pain	❐	❐	Bloody or Black Tarry Stools	❐	❐	Breathing Difficulties	❐	❐
Cough	❐	❐	Pain or Burning Urination	❐	❐	Numbness or Tingling	❐	❐
Dizziness	❐	❐	Loss of Control of Bowels	❐	❐	Vision Changes	❐	❐
Diarrhea	❐	❐	Headaches or Migraines	❐	❐	Abdominal Pain	❐	❐
Fainting Spells	❐	❐	Unexpected Weight Loss	❐	❐	Irregular Heart Beat	❐	❐
Fever or Chills	❐	❐	Difficulty Starting Urine	❐	❐	Nausea or Vomiting	❐	❐

Height: ________ Weight: ________ B/P: ________ Pulse: ________

Patient/Guardian's Signature: ____________ Date: ________

Reviewed by: ____________ Date: ________

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