ProOrtho
a division of PROLIANCE SURGEONS INC., P.S.

Patient Health History Form

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DEMOGRAPHICS

Patient Name: _____

Date of Birth: _____

Male: ○ Female: ○ (Pregnant: No ○ Yes ○ Unsure ○)

Height: _____ Weight: _____

Office Use: BP:_____ HR:_____

Referring Physician: _____

Primary Care Physician: _____

What are you being seen for today? _____

_____

PAST MEDICAL HISTORY

	Explain		Explain
○ Anemia		○ Kidney/ bladder infections	
○ Arthritis (“wear and tear”)		○ Kidney stones	
○ Asthma		○ Kidney problems, other	
○ Bad teeth		○ Liver problems	
○ Bleeding problems		○ Lupus	
○ Blood clots		○ MRSA	
○ Cancer		○ Osteoporosis or osteopenia	
○ COPD/ Emphysema		○ Prostate problems	
○ Depression		○ Psoriasis	
○ Diabetes		○ Psychiatric problems	
○ Drug or alcohol problems		○ Rheumatoid arthritis	
○ GERD/ reflux		○ Scoliosis	
○ Glaucoma		○ Seizures	
○ Gout		○ Stroke	
○ Hearing problems		○ Thyroid problems	
○ Heart attack		○ Tuberculosis	
○ Heart disease		○ Ulcerative colitis/ Crohn’s	
○ Hepatitis		○ Ulcers	
○ High blood pressure		○ Other:	
○ HIV positive/ AIDS			

ProOrtho Patient Health History Form- Page 2

PAST SURGICAL HISTORY

Please list the surgical procedures you have undergone:

Date of Surgery	Type of Surgery	Describe the Recovery
1)		
2)		
3)		
4)		
5)		
6)		
7)		
8)		
9)		
10)		

Have you ever had a blood transfusion? ○ No ○ Yes, what date? _____

Have you or any relatives had problems with anesthesia? ○ No ○ Yes, explain _____

Have you ever had an EKG? ○ No ○ Yes, when/ where? _____

Do you get shortness of breath when climbing more than 2 flights of stairs? ○ No ○ Yes

MEDICATIONS

Please list ALL medications and doses that you are CURRENTLY taking (this includes birth control pills, hormones, IUDs, vitamins and herbal supplements):

Medication	Dose/ Strength	# Pills per Day	Reason
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			
9)			
10)			

ProOrtho Patient Health History Form- Page 3

ALLERGIES

○ I have no allergies to medication.

Medication	Reaction	Medication	Reaction
1) _____	_____	4) _____	_____
2) _____	_____	5) _____	_____
3) _____	_____	6) _____	_____

Latex allergy? ○ No ○ Yes

Food allergy? ○ No ○ Yes, type_____

Please list below any pain medications you do not tolerate.

_____

FAMILY HISTORY: *Please check any conditions associated with your immediate family members*

	Mother	Father	Son	Daughter	Brother	Sister	Other
Anesthesia Problems							
Arthritis							
Back Pain							
Blood Clots							
Cancer: Breast							
Cancer: Colon							
Cancer: _____							
COPD/Emphysema							
Depression							
Diabetes							

	Mother	Father	Son	Daughter	Brother	Sister	Other
Drug & Alcohol Addiction							
Heart Disease							
High Blood Pressure/Hypertension							
Malignant Hyperthermia							
Osteoporosis / Osteopenia							
Rheumatoid Arthritis							
Sleep Apnea							
Stroke							
Other: _____							
Other: _____							

SOCIAL HISTORY

Do you use tobacco products?

○ Yes, I smoke_____packs per day

○ Yes, I currently chew tobacco/ snuff

○ No, I quit smoking/ chewing _____years_____months ago

○ No, I have never used tobacco products

Current situation?

○ Married ○ Divorced

○ Single ○ Widowed

○ Separated

○ Living with significant other

Do you consume alcoholic beverages (e.g., beer, wine, liquor)?

○ No ○ Yes, type: _____amount/ week: _____

Do you use illicit drugs? ○ No ○ Yes, type: _____

Do you have children?

○ No ○ Yes, how many? _____

Do you live: ○ alone ○ with spouse, family, and/ or friend(s) ○ assisted living

Have you had a recent change in a significant relationship in the last year or other stress? ○ No ○ Yes

If yes, please explain: _____

WORK HISTORY

What is your occupation or previous one if currently not working?_____

Briefly describe your job:_____

Name of employer:_____ **Last date worked:**_____

Please mark ONE statement that best describes your current employment situation:

○ currently working
○ on paid leave
○ on unpaid leave
○ unemployed
○ student
○ homemaker
○ disabled/ retired from an orthopedic and/or spine problem
○ disabled/ retired from a health problem (NOT from an orthopedic or spine problem)
○ retired (not due to health)
○ other, please specify_____

ProOrtho Patient Health History Form- Page 4

REVIEW OF SYSTEMS

Please mark the circle next to ANY symptoms you have experienced in the past 6 months:

Constitutional	**Cardiovascular**	**Gastrointestinal**	**Skin**
○ recent weight gain >10 lbs.	○ heart trouble	○ nausea/ vomiting	○ rashes
○ recent weight loss >10 lbs.	○ chest pain	○ constipation	○ psoriasis
○ loss of appetite	○ heart murmur	○ diarrhea	○ bruise easily
○ fatigue	○ palpitations	○ blood in your stool	○ abnormal lumps
○ insomnia	○ irregular heartbeat	○ loss of bowel control	○ painful breasts
○ fever/ chills	○ varicose veins	○ abdominal pain	○ change in skin color
○ night sweats	○ swelling of the feet/ ankles		○ change in hair or nails
		Genitourinary	
Eyes/ Ears	**Respiratory**	○ blood in your urine	**Neurologic**
○ eye disease	○ shortness of breath	○ increased frequency of urination	○ headache/ migraine
○ glasses or contacts	○ wheezing	○ urgency of urination	○ dizziness
○ blurred or double vision	○ chronic cough	○ painful urination	○ convulsions/ seizures
○ vision loss	○ COPD/ emphysema	○ loss of bladder control	○ loss of consciousness
○ hearing loss		○ kidney stones	
○ ringing in the ears	**Hematologic**	○ incontinence	**Mental Health**
	○ bleeding tendency	○ sexual difficulty	○ depression
Nose	○ anemia		○ nervousness
○ sinus problems	○ recurrent infections	**Musculoskeletal**	○ hallucinations
○ nose bleeds		○ fractures/ sprains	○ anxiety
	Endocrine	○ osteoporosis	○ unusual stress in home life
Throat/ Mouth	○ thyroid problems	○ joint swelling	○ unusual stress in work life
○ sore throat	○ heat or cold intolerance	○ joint pain	**Other:**
○ mouth sores	○ excessive thirst/ appetite	○ weakness of muscles or joints	
○ hoarseness	○ diabetes	○ muscle pain or cramps	
○ sleep apnea	○ glandular or hormone problems	○ back pain	
○ swollen glands in the neck		○ difficulty walking	

○ I have not had ANY of the above symptoms in the last 6 months.

SIGNATURE

Patient's signature: _____ Date: _____

Please print name: _____

Physician's signature: _____ Date: _____

Please print name: _____