ProOrtho
a divison of PROLIANCE SURGEONS, INC., P.S.
ORTHOPEDICS & SPORTS MEDICINE
Personalized care. Optimal results.

Patient Health History Form

Phone: (425) 823 - 4000 Fax: (425) 821 - 3550

PATIENT LABEL:

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

Height: _____ Weight: _____

Office Use: BP: _____ HR: _____

Referring Physician: _____

Primary Care Physician: _____

What are you being seen for today? _____

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.

_____

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)			

Have you ever had history of anemia or blood disorder? ○ No ○ Yes, explain _____

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

POS Reorder # 1900124

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PATIENT LABEL:

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)		

PAST MEDICAL HISTORY

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

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PATIENT LABEL:

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

	Mother	Father	Son	Daughter	Brother	Sister	Other
Anesthesia Problems							
Arthritis							
Back Pain							
Cancer: _____							
Clotting Disorder							
COPD/Emphysema							
Diabetes							
Drug Addiction							
Alcohol Addiction							

	Mother	Father	Son	Daughter	Brother	Sister	Other
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_____

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PATIENT LABEL:

REVIEW OF SYSTEMS

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

Constitutional	**Eyes**	**Gastrointestinal**	**Other**
○ Fever	○ Blurred Vision	○ Heartburn	○ Easy Bruise/Bleed
○ Chills	○ Double Vision	○ Nausea	○ Environmental Allergies
○ Weight Loss	○ Sensitivity to Light	○ Vomiting	○ Other_____
○ Malaise/Fatigue	○ Eye Pain	○ Abdominal Pain	
○ Sweating	○ Eye Discharge	○ Diarrhea	**Neurological**
○ Weakness	○ Eye Redness	○ Constipation	○ Dizziness
○ Other_____	○ Other_____	○ Blood in Stool	○ Headaches
		○ Melena	○ Tingling
Skin	**Cardiovascular**	○ Other_____	○ Tremor
○ Rash	○ Chest Pain		○ Sensory Change
○ Itching	○ Palpitations	**Genitourinary**	○ Speech Change
○ Other_____	○ Shortness of Breath	○ Painful Urination	○ Focal Weakness
	○ Leg Cramps	○ Urgency of Urination	○ Seizures
HENT	○ Leg Swelling	○ Frequency of Urination	○ Loss of Consciousness
○ Hearing Loss	○ Sleep Apnea	○ Blood in Urine	○ Other_____
○ Ringing in Ears	○ Other_____	○ Flank Pain	
○ Ear Pain		○ Other_____	**Mental Health**
○ Ear Discharge	**Respiratory**		○ Depression
○ Nosebleeds	○ Coughs	**Musculoskeletal**	○ Suicidal Ideas
○ Congestion	○ Coughing up Blood	○ Muscle Pain	○ Substance Abuse
○ Sinus Pain	○ Sputum Production	○ Neck Pain	○ Hallucinations
○ Stridor	○ Shortness of Breath	○ Back Pain	○ Nervous/Anxious
○ Sore Throat	○ Wheezing	○ Joint Pain	○ Insomnia
○ Excessive Thirst	○ Other_____	○ Falls	○ Memory Loss
○ Other_____		○ Other_____	○ Other_____

○ **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: _____