Patient Health History

Name:
Chart:
Date:

Male / Female Age_____ **Family Physician**_____**Referred by**_____

Area of complaint_____ **Left Right**
Injury? **Yes No** Work Related? **Yes No**
Date of injury or symptom onset _____

How and where did injury occur _____

Prior Treatment **Yes No** By whom?
ER Urgent Care Family Physician Other

Activities that aggravate symptoms_____

Activities that alleviate symptoms_____

Physician/Physician Assistant/Nurse/Assistant Notes

Medications with dosages and directions
Prescription, OTC, Vitamins, Supplements

Office Use Only

BP_____ HTN meds **Yes No**

Pulse_____ Resp_____

Temp_____ Height_____

SaO2_____**RA O2** Weight_____

O2_____L **Cont NOC**

Social History

Single Married Divorced Widow(ed)

Alcohol Yes No How much_____

Tobacco Yes No Former Quit date_____

Allergies and reactions (eg. Hives, Swelling, Vomiting)

Cigarettes_____packs/day Year started smoking_____

Chew _____cans/week Year started chewing_____

Caffeine **Yes No** _____

Drugs **Yes No** _____

Pharmacy name & number List city if not Idaho Falls

Occupation and Job description

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Conditions	Please circle all that apply	Fill in any blanks that apply	Add any condition not listed
HIV/ AIDS	Emphysema	Migraine Headache	Heart Disease
Alcoholism	Asthma	Multiple Sclerosis	Heart Attack date_____
Chemical Dependency_____	Cancer(type)_____	Parkinson's Disease	Pacemaker date_____
substance	Location_____	Pneumonia in past year	Stroke date_____
Anemia	Diabetes Type I Type II	Thyroid Problem	Stent date_____
Anorexia	Epilepsy	Prostate Problem	Coronary artery disease
Arthritis(type)_____	Glaucoma/Cataracts	Psychiatric Care	Peripheral vascular disease
Gout	Liver Disease	Diagnosis_____	Arrythmia
Bleeding disorder	Hepatitis A B C D E	Suicide attempt when_____	Angina/Chest Pain
Blood thinner_____	High Blood Pressure	Other	Other
COPD	High Cholesterol		
Lung Disease	Kidney Disease		**Cardiologist Name & #**
Chronic Bronchitis	Dialysis(type)_____		
Staph Infection YES NO	Autoimmune disorder		
When/Where	type		

Circle if your blood relative(s) have any of the following	**Family history: Age and cause of death** (if known)	**Personal Surgical History** (include **all** surgeries you have had and which side **(left/right)** if it applies)
Anesthetic Complications	Father	
Arthritis		
Gout	Mother	
Asthma		
Bleeding disorder	Brother	
Cancer Type_____		
Diabetes	Brother	
Heart Disease		
High Blood Pressure	Brother	
Stroke		
Kidney disease	Sister	
Lung Disease		
Autoimmune disorder	Sister	
Liver Disease		
Other	Sister	
	Other	

Have you ever had a blood transfusion **Yes No** Did you have any reaction **Yes No** _____

Have you ever had a complication to Anesthesia? **Yes No NA** What was the reaction? _____

Have you ever had a blood clot? **Yes No NA** Where was it located?_____ Date_____

By signing below, I certify the information I have provided is correct to the best of my knowledge. I will not hold Summit Orthopaedics, Physicians or staff responsible for any errors or omissions I may have made in completing this form.
I give Summit Orthopaedics and staff permission to obtain my medication history, and to provide that history to anyone involved in my care when necessary.

Today's Date:_____ **Signature** _____