PATIENT HEALTH HISTORY

ADVANCED ORTHOPEDICS NEW ENGLAND

Patient Name:_____DOB:___/___/___ **Treating Orthopedic Doctor:**_____

Chief Complaint (why are you here today?): _____

When did the symptoms begin?_____

How did incident occur? ☐ Motor vehicle accident ☐ At work ☐ At School ☐ Home ☐ other: _____

Injury mechanism: ☐ no injury mechanism ☐ direct blow ☐ fall ☐ twisting injury

Height:_____ **Weight:**_____ **Occupation:** _____

Allergies: ☐ No known Allergies _____

ALL current medications (including over the counter): ☐ Not taking any medications _____

_____

_____

PAST MEDICAL HISTORY	YES	NO	PAST MEDICAL HISTORY	YES	NO
Anemia			HIV/AIDS/Hepatitis		
Asthma			Hypo/Hyperthyroidism		
Blood Clot/DVT			Lyme Disease		
Cancer:			Osteoporosis/Osteopenia		
COPD			Peripheral Vascular Disease		
Diabetes Type I/Type II			Psoriasis		
Gout			Renal Failure/Kidney Disease		
Heart Attack/Angina			Rheumatoid Arthritis/Lupus		
Heart Disease/**Pacemaker**			Stroke		
High Blood Pressure			Tuberculosis		
History of Blood Transfusion			Ulcer/Acid Reflux/GERD		
History of Prednisone or Steroid Medication			Other:		

PAST SURGERIES	SURGEON	DATE

FAMILY HISTORY: Please check all that apply ☐ Family History Unknown ☐ Adopted

Relationship	Anesthesia Problems	Arthritis	Blood Clots	Cancer	Diabetes	Heart Disease	High Cholesterol	Hypertension	Rheumatologic Disease	Scoliosis
Mother										
Father										
Sister										
Brother										

ALCOHOL USE: ☐ Yes ☐ No - **Drinks/Week**_____ ☐ wine ☐ beer ☐ liquor **DRUG USE:** ☐ Yes ☐ No

TOBACCO USE	Cigarettes	Cigars	Pipe	Chew	Snuff	Smokeless Tobacco
NEVER						
START DATE						
QUIT DATE						
PACKS/DAY						