WEST MICHIGAN ORTHOPAEDICS

PATIENT HEALTH HISTORY

PATIENT NAME _____ DATE OF BIRTH _____

DRUG ALLERGIES _____ HEIGHT_____ WEIGHT_____ BMI_____

CURRENT MEDICATIONS _____

_____

PREVIOUS SURGERY(S) _____

NATURE OF PROBLEM/INJURY

CHIEF COMPLAINT _____ WHEN DID IT FIRST OCCUR? _____

WHAT MAKES IT BETTER? _____ WHAT MAKES IT WORSE? _____

WHAT TREATMENT HAVE YOU HAD? _____

RATE YOUR PAIN ON A SCALE 0-10 (0=NONE; 10=SEVERE) _____ WORK RELATED? ☐ Yes ☐ No

HAVE YOU SEEN ANOTHER PHYSICIAN REGARDING THIS PROBLEM? ☐ YES ☐ NO IF YES, NAME(S):_____

MEDICAL PROBLEMS

Have you had or do you currently have any of the following? *If none, check here:* ☐

___ High blood pressure
___ Heart disease
___ Diabetes
___ Thyroid disorder
___ Respiratory / lung disorder
___ Cancer
___ HIV / Hepatitis infection
___ Stroke
___ Other _____

REVIEW OF SYSTEMS

Have you had or do you currently have any of the following? *If none, check here:* ☐

___ Arthritis
___ Chest pain
___ Shortness of breath
___ Asthma
___ Heartburn/ulcers
___ Skin rash/dermatitis
___ Fevers
___ Recent infection
___ History of blood clots
___ Bleeding problems
___ Anesthesia problems
___ Severe headaches/migraines
___ Unexplained weight loss
___ History of steroid (prednisone) use
___ Environmental allergies
___ Excessive fatigue/weakness
___ Limited exercise/walking tolerance
___ Other _____

SOCIAL HISTORY

Marital status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Housing status: ☐ Live alone ☐ Live with spouse/partner ☐ Live in nursing/assisted care facility ☐ Other _____

Do you use tobacco? ☐ Yes ☐ No If yes, type and how much? _____

Do you consume alcoholic beverages? ☐ Yes ☐ No If yes, average drinks per day? _____

Occupation:_____

FAMILY HISTORY

Do you have a family history of any of the following? *If none, check here:* ☐

___ Heart problems
___ High blood pressure
___ Diabetes
___ Stroke
___ Cancer
___ Other_____

OSTEOPOROSIS SCREENING

Results of a previous bone density scan: ☐ Never tested ☐ Normal ☐ Low

Daily calcium intake (type/dose): _____

Have you ever broken a bone? ☐ Yes ☐ No If yes, which bone(s)_____

Do you have a family history of broken bones/osteoporosis? ☐ Yes ☐ No

PATIENT SIGNATURE _____ **DATE** _____

(REV 03/09)

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