



Patient Health History Form

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DEMOGRAPHICS

Patient Name: _____	Height: _____ Weight: _____ Office Use: BP: _____ HR: _____
Male: <input type="radio"/> Female: <input type="radio"/> (Pregnant: No <input type="radio"/> Yes <input type="radio"/> Unsure <input type="radio"/>)	

Have you filed a Worker's Compensation claim for your injury? No Yes , what date: _____

Have you worked with a lawyer as a result of your injury? No Yes

What are you being seen for today? _____

PAST MEDICAL HISTORY

	Explain		Explain
<input type="radio"/> Anemia		<input type="radio"/> Kidney/ bladder infections	
<input type="radio"/> Arthritis ("wear and tear")		<input type="radio"/> Kidney stones	
<input type="radio"/> Asthma		<input type="radio"/> Kidney problems, other	
<input type="radio"/> Bad teeth		<input type="radio"/> Liver problems	
<input type="radio"/> Bleeding problems		<input type="radio"/> Lupus	
<input type="radio"/> Blood clots		<input type="radio"/> MRSA	
<input type="radio"/> Cancer		<input type="radio"/> Osteoporosis or osteopenia	
<input type="radio"/> COPD/ Emphysema		<input type="radio"/> Prostate problems	
<input type="radio"/> Depression		<input type="radio"/> Psoriasis	
<input type="radio"/> Diabetes		<input type="radio"/> Psychiatric problems	
<input type="radio"/> Drug or alcohol problems		<input type="radio"/> Rheumatoid arthritis	
<input type="radio"/> GERD/ reflux		<input type="radio"/> Scoliosis	
<input type="radio"/> Glaucoma		<input type="radio"/> Seizures	
<input type="radio"/> Gout		<input type="radio"/> Stroke	
<input type="radio"/> Hearing problems		<input type="radio"/> Thyroid problems	
<input type="radio"/> Heart attack		<input type="radio"/> Tuberculosis	
<input type="radio"/> Heart disease		<input type="radio"/> Ulcerative colitis/ Crohn's	
<input type="radio"/> Hepatitis		<input type="radio"/> Ulcers	
<input type="radio"/> High blood pressure		<input type="radio"/> Other:	
<input type="radio"/> 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? <input type="radio"/> No <input type="radio"/> Yes		Please list below any pain medications you do not tolerate. _____	
Food allergy? <input type="radio"/> No <input type="radio"/> Yes, type _____			

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

	Mother	Father	Son	Daughter	Brother	Sister	Other		Mother	Father	Son	Daughter	Brother	Sister	Other
Anesthesia Problems								Drug & Alcohol Addiction							
Arthritis								Heart Disease							
Back Pain								High Blood Pressure/Hypertension							
Blood Clots								Malignant Hyperthermia							
Cancer: Breast								Osteoporosis / Osteopenia							
Cancer: Colon								Rheumatoid Arthritis							
Cancer: _____								Sleep Apnea							
COPD/Emphysema								Stroke							
Depression								Other: _____							
Diabetes								Other: _____							

SOCIAL HISTORY

<p>Do you use tobacco products?</p> <p><input type="radio"/> Yes, I smoke _____ packs per day</p> <p><input type="radio"/> Yes, I currently chew tobacco/ snuff</p> <p><input type="radio"/> No, I quit smoking/ chewing _____ years _____ months ago</p> <p><input type="radio"/> No, I have never used tobacco products</p>	<p>Current situation?</p> <p><input type="radio"/> Married <input type="radio"/> Divorced</p> <p><input type="radio"/> Single <input type="radio"/> Widowed</p> <p><input type="radio"/> Separated</p> <p><input type="radio"/> Living with significant other</p>
<p>Do you consume alcoholic beverages (e.g., beer, wine, liquor)?</p> <p><input type="radio"/> No <input type="radio"/> Yes, type: _____ amount/ week: _____</p>	<p>Do you have children?</p> <p><input type="radio"/> No <input type="radio"/> Yes, how many? _____</p>
<p>Do you use illicit drugs? <input type="radio"/> No <input type="radio"/> Yes, type: _____</p>	
<p>Do you live: <input type="radio"/> alone <input type="radio"/> with spouse, family, and/ or friend(s) <input type="radio"/> assisted living</p>	
<p>Have you had a recent change in a significant relationship in the last year or other stress? <input type="radio"/> No <input type="radio"/> Yes</p> <p>If yes, please explain: _____</p>	

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 student disabled/ retired from a health problem (NOT from an orthopedic or spine problem)
 on paid leave homemaker
 on unpaid leave disabled/ retired from an orthopedic retired (not due to health)
 unemployed and/or spine problem 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
<input type="checkbox"/> recent weight gain >10 lbs.	<input type="checkbox"/> heart trouble	<input type="checkbox"/> nausea/ vomiting	<input type="checkbox"/> rashes
<input type="checkbox"/> recent weight loss >10 lbs.	<input type="checkbox"/> chest pain	<input type="checkbox"/> constipation	<input type="checkbox"/> psoriasis
<input type="checkbox"/> loss of appetite	<input type="checkbox"/> heart murmur	<input type="checkbox"/> diarrhea	<input type="checkbox"/> bruise easily
<input type="checkbox"/> fatigue	<input type="checkbox"/> palpitations	<input type="checkbox"/> blood in your stool	<input type="checkbox"/> abnormal lumps
<input type="checkbox"/> insomnia	<input type="checkbox"/> irregular heartbeat	<input type="checkbox"/> loss of bowel control	<input type="checkbox"/> painful breasts
<input type="checkbox"/> fever/ chills	<input type="checkbox"/> varicose veins	<input type="checkbox"/> abdominal pain	<input type="checkbox"/> change in skin color
<input type="checkbox"/> night sweats	<input type="checkbox"/> swelling of the feet/ ankles		<input type="checkbox"/> change in hair or nails
		Genitourinary	
Eyes/ Ears	Respiratory	<input type="checkbox"/> blood in your urine	Neurologic
<input type="checkbox"/> eye disease	<input type="checkbox"/> shortness of breath	<input type="checkbox"/> increased frequency of urination	<input type="checkbox"/> headache/ migraine
<input type="checkbox"/> glasses or contacts	<input type="checkbox"/> wheezing	<input type="checkbox"/> urgency of urination	<input type="checkbox"/> dizziness
<input type="checkbox"/> blurred or double vision	<input type="checkbox"/> chronic cough	<input type="checkbox"/> painful urination	<input type="checkbox"/> convulsions/ seizures
<input type="checkbox"/> vision loss	<input type="checkbox"/> COPD/ emphysema	<input type="checkbox"/> loss of bladder control	<input type="checkbox"/> loss of consciousness
<input type="checkbox"/> hearing loss		<input type="checkbox"/> kidney stones	
<input type="checkbox"/> ringing in the ears	Hematologic	<input type="checkbox"/> incontinence	Mental Health
	<input type="checkbox"/> bleeding tendency	<input type="checkbox"/> sexual difficulty	<input type="checkbox"/> depression
Nose	<input type="checkbox"/> anemia		<input type="checkbox"/> nervousness
<input type="checkbox"/> sinus problems	<input type="checkbox"/> recurrent infections	Musculoskeletal	<input type="checkbox"/> hallucinations
<input type="checkbox"/> nose bleeds		<input type="checkbox"/> fractures/ sprains	<input type="checkbox"/> anxiety
	Endocrine	<input type="checkbox"/> osteoporosis	<input type="checkbox"/> unusual stress in home life
Throat/ Mouth	<input type="checkbox"/> thyroid problems	<input type="checkbox"/> joint swelling	<input type="checkbox"/> unusual stress in work life
<input type="checkbox"/> sore throat	<input type="checkbox"/> heat or cold intolerance	<input type="checkbox"/> joint pain	Other:
<input type="checkbox"/> mouth sores	<input type="checkbox"/> excessive thirst/ appetite	<input type="checkbox"/> weakness of muscles or joints	
<input type="checkbox"/> hoarseness	<input type="checkbox"/> diabetes	<input type="checkbox"/> muscle pain or cramps	
<input type="checkbox"/> sleep apnea	<input type="checkbox"/> glandular or hormone	<input type="checkbox"/> back pain	
<input type="checkbox"/> swollen glands in the neck	problems	<input type="checkbox"/> 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: _____