



ORTHOGEORGIA
Orthopaedic Specialists

HEALTH HISTORY

NAME _____ AGE _____ WERE YOU REFERRED BY A PHYSICIAN? [] YES [] NO

WHO REQUESTED OUR SERVICES? _____

REASON FOR SEEKING MEDICAL ATTENTION _____ [] RIGHT [] LEFT [] BOTH

DATE OF INJURY OR DURATION OF SYMPTOMS _____ WORK RELATED? [] YES [] NO

HAVE YOU HAD ANY DIAGNOSTIC STUDIES FOR THIS CONDITION, SUCH AS MRI, BONE SCAN, ETC? [] YES [] NO

IF YES, PLEASE LIST: _____

HAVE YOU SEEN ANYONE FOR THIS CONDITION? [] YES [] NO

IF YES, PLEASE LIST NAMES AND DATES: _____

HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING CHRONIC CONDITIONS? (CHECK IF YOU HAVE)

- [] AIDS/HIV [] ALCOHOLISM [] ALZHEIMERS [] ANEMIA [] ANGINA [] ARTHRITIS [] ASTHMA [] ATRIAL FIBRILATION [] BENIGN PROSTATIC HYPERTROPHY [] CANCER, TYPE _____ [] CEREBROVASCULAR ACCIDENT [] CONGESTIVE HEART FAILURE [] COPD [] CORONARY ARTERY DISEASE [] CROHN'S DISEASE [] DEGENERATIVE JOINT DISEASE [] DEPRESSION [] DIABETES [] DRUG ABUSE [] DVT [] FIBROMYALGIA [] GALLBLADDER DISEASE [] GERD [] GOUT [] HEPATITIS [] HYPERLIPIDEMIA [] HYPERTENSION [] INFLAMMATORY BOWEL DISEASE [] JUVENILE RHEUMATOID ARTHRITIS [] KIDNEY DISEASE [] LIVER DISEASE [] LYME DISEASE [] MIGRAINE HEADACHES [] MULTIPLE SCLEROSIS [] MYOCARDIAL INFARCTION [] OBESITY [] OSTEOARTHRITIS [] OSTEOPOROSIS [] PARKINSON DISEASE [] PEPTIC ULCER DISEASE [] PSORIASIS [] PVD [] RENAL DISEASE [] RHEUMATOID ARTHRITIS [] SCOLIOSIS [] SEIZURE DISORDER [] SLEEP APNEA [] SLE [] SPINAL STENOSIS [] SPONDYLOARTHROPATHY [] THYROID DISEASE [] VALVULAR DISEASE

OTHER MEDICAL CONDITIONS: _____

ARE THERE LAWSUITS PENDING ON YOUR ORTHOPAEDIC CONDITION? [] YES [] NO

PLEASE LIST ANY SURGERIES:

PLEASE LIST CURRENT MEDICATIONS AND DOSAGE:

Table with columns: PROCEDURE, YEAR, and medication/dosage lines.

ARE YOU ALLERGIC TO: (CHECK IF YOU ARE)

- [] ADHESIVE TAPE [] ARTHRITIS MEDICINES [] ASPIRIN [] CECLOR [] CEPHALOSPORIN [] CIPRO [] CODEINE [] DYES [] IBUPROFEN [] IODINE [] LATEX [] LIDOCAINE [] MORPHINE [] MYCINS [] OXYCODONE [] PENICILLAN [] SULFA [] TETANUS

FOODS (PLEASE LIST): _____

OTHERS: _____

DO YOU CURRENTLY USE TOBACCO: [] CIGARETTES [] PIPE [] SMOKELESS AMOUNT PER DAY: _____ QUIT WHEN? _____

DO YOU DRINK ALCOHOL: [] BEER [] LIQUOR [] WINE AMOUNT PER DAY: _____ PER WEEK: _____

HAS ANYONE IN YOUR FAMILY HAD:

[] HIGH BLOOD PRESSURE [] HEART DISEASE [] CANCER* TYPE _____ [] DIABETES [] BLEEDING PROBLEMS [] LUNG DISEASE

HAVE YOU RECENTLY HAD ANY OF THE FOLLOWING PROBLEMS OR SYMPTOMS?

Table with columns: YES, NO for various symptoms like CHEST PAIN, BREATHING DIFFICULTIES, etc.

PATIENTS SIGNATURE: _____ DATE: _____ PHYSICIANS SIGNATURE: _____