

GEORGIA BONE AND JOINT, LLC

HEALTH HISTORY

PATIENT NAME _____ DOB ____ / ____ / ____ AGE ____ HEIGHT: ____ WEIGHT: ____

REFERRING PHYSICIAN: _____

FAMILY PHYSICIAN: _____

ADDRESS: _____

ADDRESS: _____

PHONE: _____

PHONE: _____

TO HELP US MEET ALL YOUR HEALTHCARE NEEDS, PLEASE FILL OUT THIS FORM COMPLETELY. THIS IS A CONFIDENTIAL RECORD OF YOUR MEDICAL HISTORY AND WILL BE KEPT IN THIS OFFICE.

Reason for your visit _____ (Circle One) Injury/ Sports Related Injury Date: _____

1. ORTHOPEDIC HISTORY

- Arthroscopy of what? Back/Neck Surgery/date Joint Replacement/where Orthopedic Surgery Fractures of what area

2. PAST MEDICAL HISTORY - Have you ever had the following: I deny any past medical illness(s)

Table with 3 columns: Condition, Dates, Condition, Dates, Condition, Dates. Includes Diabetes, Hypertension, Thyroid, Parkinson, Multiple Sclerosis, Heart Disease, Asthma, Bleeding Disorder, Rheumatoid Arthritis, Lupus, etc.

3. PAST SURGICAL HISTORY - Have you ever had the following: I deny any surgeries

Please list all serious illnesses, operations & other hospitalizations you have experienced and indicate year these occurred

- Appendectomy Gall Bladder removal Mastectomy Abdominal Colon resection Prostate Bladder Heart Tonsillectomy Breast biopsy Hernia Other Surgeries Cataract Hysterectomy Other Surgeries

4. MEDICATIONS: Please list all medicines you are currently taking please continue on back of sheet

I deny taking any Medications

Table with 3 columns: CURRENT MEDICATIONS, DOSAGE (mg), how often per day? with multiple rows for entry.

5. Please list all ALLERGIES (food, drugs, and environment)

___ I deny any Allergies

6. FAMILY HISTORY: Has any blood relative had any of the following: (Please check, leave blank if uncertain)

___ I deny family history

- Any Cancer/type _____ Relationship _____
- Bleeding Disorder _____
- Osteoarthritis _____
- Heart Disease _____
- Hypertension _____

- Muscle/Bone Disorder _____ Relationship _____
- Diabetes _____
- Malignant Hyperthermia _____
- Lupus _____

7. SOCIAL HISTORY:

Smoking (type & amount) _____
Alcohol (type & amount per week) _____
Street drugs (type & amount per day) _____

If former smoker, date quit _____
Occupation: _____
Marital Status: _____

8. REVIEW OF SYSTEMS:

**DO YOU HAVE NOW OR HAVE YOU HAD ANY OF THE BELOW PROBLEM WITHIN THE PAST YEAR:
(Please circle anything for which you have a history of)**

Constitutional: fever, chills, fatigue, weight change, poor appetite, night sweats

Eyes: change in vision, blurred vision, impaired vision,

HENT: sore throat, nasal congestion, headaches, hearing loss,

Breast: lumps, tenderness,

Cardiovascular: chest pain, cardiac murmur, irregular heartbeats, rapid heart, dyspnea on exertion, ankle swelling,

Respiratory: coughing, shortness of breath, sleep apnea, wheezing,

Gastrointestinal: heartburn, loss of appetite, nausea, vomiting, irritable bowel syndrome, diarrhea, constipation, jaundice, constipation, blood in stools

Genitourinary: urgency, frequency, dysuria, nocturia, hematuria, incontinence, urinary tract infection, urinary retention, difficulty voiding, urinary hesitancy, decreased stream, post void dribbling, decreased libido, impotence,

Integument: rash, itching, new lesion,

Neurological: tingling or numbness, incoordination, history of stroke, memory difficulties, seizures, tremors

Musculoskeletal: back pain, joint pain, muscle pain,

Endocrine: excessive thirst, loss of hair, increased libido, hot flashes,

Psychiatric: anxiety, depression, suicidal thoughts

Heme-Lymph: easy bleeding, easy bruising, lymph node enlargement or tenderness,

Allergic- Immunologic: sinus allergy symptoms, allergic dermatitis,

Signature of pt or parent of minor

Date