SOUTH BEND ORTHOPAEDICS

PATIENT HEALTH HISTORY

PATIENT INFORMATION

Patient Name: ______________________________ Date of Birth: ____________

PATIENT INFORMATION

List All Allergies (Including medications): ______________________________

Height: ________________ Weight: _______________

Current Medication List:
(If you have a written list, we can copy it for you.)

Medication: __________________ Strength/Dose: ______
Medication: __________________ Strength/Dose: ______
Medication: __________________ Strength/Dose: ______
Medication: __________________ Strength/Dose: ______
Medication: __________________ Strength/Dose: ______

Vaccine Information:

Date of Last Flu Vaccine: ________________ ☐ N/A
Date of Last Pneumonia Vaccine: ___________ ☐ N/A

Have you fallen in the last 12 months? ☐ Yes ☐ NO
If so, how many times? _______________
Were you injured? ☐ Yes ☐ NO

FAMILY HISTORY

Indicate family members who have been diagnosed with any of the following (check all that apply):

	Father	Mother	Brother	Sister
History of Anesthesia Problem:	☐	☐	☐	☐
Family History of Cancer:	☐	☐	☐	☐
Heart Disease:	☐	☐	☐	☐
Hypertensive Disorder (High Blood Pressure):	☐	☐	☐	☐
Arthritis:	☐	☐	☐	☐
Osteoporosis:	☐	☐	☐	☐
Cerebrovascular Accident (Stroke):	☐	☐	☐	☐
Type 1 Diabetes	☐	☐	☐	☐
Type 2 Diabetes	☐	☐	☐	☐
Family History of Bleeding/Clotting:	☐	☐	☐	☐

SOCIAL HISTORY

Smoking Status: Never Former Everyday Some Days

How many years ago did you quit smoking? 1-5 6-10 11-15 16+

Smoking - # of Years ____ years

Alcohol Use: None Occasional Moderate Heavy

Drug Dependency or Addiction? ☐ YES ☐ NO

Recreational Drug Use? ☐ YES ☐ NO

Do you have an advance directive/living will? ☐ YES ☐ NO

Hand Dominance? Left Right Both

What is your exercise level? None Occasional Moderate Heavy

Occupation ______________________

What sports do you participate in? ______________________

SURGICAL HISTORY

Surgery: ______________________________
Surgery: ______________________________
Surgery: ______________________________

Date of Last Colonoscopy: ______________

Date of Last Mammogram: ______________

Have you been diagnosed with any of the following problems? (Check all that apply):

☐ AIDS	☐ COPD	☐ Heart Attack	☐ Migraines	
☐ Alcohol Abuse	☐ Congestive Heart Failure	☐ Heart Disease	☐ Multiple Sclerosis	☐ Reflux/GERD
☐ Amputation	☐ Coronary Artery Disease	☐ Hepatitis	☐ Neck Injury	☐ Rheumatoid Arthritis
☐ Anesthesia Complications	☐ Crohn's Disease	☐ High Cholesterol	☐ Neurologic Disorder	☐ Serious Illness/Injuries
☐ Anxiety Disorder	☐ Depression	☐ HIV	☐ Neuropathy	☐ Skin Problems
☐ Artificial joints	☐ Diabetes	☐ Hyperlipidemia	☐ Organ Transplant	☐ Sleep Apnea
☐ Atrial Fibrillation	☐ Emphysema	☐ Hypertension	☐ Osteopenia	☐ Sleep Disorder
☐ Autoimmune disease	☐ Epilepsy/Seizures	☐ Hyperthyroidism	☐ Osteoporosis	☐ Spasticity
☐ Anemia	☐ Falls	☐ Hypothyroidism	☐ Ostomy	☐ Sports Induced Asthma
☐ Arthritis	☐ Fibromyalgia	☐ Kidney Disease	☐ Pacemaker	☐ Stroke
☐ Asthma	☐ Gastrointestinal Disease	☐ Leg or Foot Ulcer	☐ Paralysis	☐ Thyroid Disease
☐ Bleeding Disorder	☐ Gout	☐ Liver Disease	☐ Parkinson's Disease	☐ Tuberculosis
☐ Blood Transfusion	☐ Head Injury/Concussion	☐ Lung Disease	☐ Peripheral Vascular	☐ Ulcers
☐ Blood Clot	☐ Head Trauma / Injury	☐ Lyme Disease	☐ Polio	☐ Urinary Problems
☐ Brain Injury	☐ Headaches	☐ Mental Illness	☐ Prostate Problems	☐ Vascular Disease
☐ Cancer	☐ Heart Arrhythmia	☐ MRSA	☐ Pulmonary Embolism	☐ Vision/Eye Problems

REVIEW OF SYSTEMS

Do you NOW have, or have you recently had any of the following symptoms? (Circle YES or NO):

ENMT		
Difficulty Hearing	Y	N
Ringing in the Ears	Y	N
Dizziness	Y	N
Sore Throat	Y	N

GASTROINTESTINAL		
Abdominal Pain	Y	N
Nausea	Y	N
Vomiting	Y	N
Constipation	Y	N
Diarrhea	Y	N

INTEGUMENTARY		
Rashes	Y	N
Lacerations	Y	N
Non-Healing Areas	Y	N
Change in Hair/Nails	Y	N
Change in skin color	Y	N
Growth/ Lesions	Y	N
Skin Pain	Y	N
Drainage	Y	N

ENDOCRINE		
Fatigue	Y	N
Cold Intolerance	Y	N
Increased Thirst	Y	N

CARDIOVASCULAR		
Chest pain	Y	N
Arm Pain on Exertion	Y	N
Shortness of breath when walking	Y	N
Shortness of breath when lying down	Y	N
Palpitations	Y	N
Heart Murmur	Y	N
Light-headed on standing	Y	N
Ankle swelling	Y	N

GENITOURINARY		
Incontinence	Y	N
Difficulty Urinating	Y	N
Increased Urination	Y	N

NEUROLOGIC		
Weakness	Y	N
Numbness	Y	N
Tingling	Y	N
Headaches	Y	N
Tremor	Y	N

HEMATOLOGIC / LYMPHATIC		
Swollen Glands	Y	N
Bruising	Y	N
Excessive Bleeding	Y	N
Anemia	Y	N

RESPIRATORY		
Cough	Y	N
Wheezing	Y	N
Shortness of Breath	Y	N
Sleep Apnea	Y	N

MUSCULOSKELETAL		
Muscle Aches	Y	N
Muscle Weakness	Y	N
Joint Pain	Y	N
Back Pain	Y	N
Swelling in the Joints	Y	N
Neck Pain	Y	N
Difficulty Walking	Y	N
Cramps	Y	N
Joint Stiffness	Y	N
Bone Deformity	Y	N

PSYCHIATRIC		
Mood Swings	Y	N
Memory Loss	Y	N
Dementia	Y	N