Orthopedic Affiliates Health History Questionnaire

Date:___________

Name:_____________________________ Date of Birth:____________________________

Primary Care Physician:_____________________ Referral Doctor:__________________________

Reason For Visit:__________________________ Occupation:_____________________________

Date of First Symptoms: ___/___/_____ ☐ MVA ☐ Work Injury Circle: Desk or Manual Job

Past Medical History: (circle all that apply)

Blood Clot/DVT/PE	Stroke	Sleep Apnea
High Blood Pressure	Osteoarthritis	Lyme Disease
High Cholesterol	Rheumatoid Arthritis	Hypothyroidism
Diabetes	Anxiety	Gout
Heart Attack	Stomach/Ulcer/GI Disorder	Kidney, Bladder Disease
Asthma/COPD	Nerve Disorder	Seizures

Other:____

Cancer:____

Surgical History:____

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Medications:

Med	Dose	Times/day	Med	Dose	Times/day

Allergies: ☐ Latex ☐ Iodine Medications:____

Vital Signs: Height (in.): _________ Weight:___________

Social History: (Please Circle) Status: Married Single Widowed Children: Yes No

Alcohol Frequency: Drinks per day____ Drinks per week____ History of Alcoholism_______

Tobacco use history, frequency, if and when stopped (packs per day)___________________

Review of Systems: (circle all that apply)

Weight Loss	Nose Bleeds	Shortness of Breath	Blood in stool	Heat Intolerance
Fever/Chills	Hearing Loss	Nausea	Urinary Retention	HIV
Fatigue	Chest Pain	Vomiting	Kidney Stones	Difficulty Walking
Vision Loss	Angina	Ulcers/GERD	Joint Swelling	Skin Rash
Eye Pain	Heart Palpitations	Constipation	Anxiety	Abnormal Bruising
Headaches		Hepatitis	Thyroid	

Familial Blood Disorders (Von Willebran/Factor V Leiden):_____________________________

Pertinent Family History: (cancer, blood disorders, etc.)

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**************Please use back of this page if you need more room to answer questions****************

Patient Signature___________________________ Provider Signature_________________________