**PATIENT HISTORY FORM**

**Nickname:**

**Are you:**
- [ ] Right handed
- [ ] Left handed
- [ ] Ambidextrous
- [ ] Male
- [ ] Female

**Height:** [ ] **Weight:** [ ]

**Medical History:** Do you currently or have had any of the following? [ ] **NONE**

- [ ] seizures
- [ ] stroke
- [ ] diabetes
- [ ] hypothyroidism
- [ ] congestive heart failure
- [ ] coronary artery disease
- [ ] heart attack
- [ ] heart murmur
- [ ] high blood pressure
- [ ] high cholesterol
- [ ] irregular heart beat
- [ ] pacemaker
- [ ] asthma
- [ ] COPD
- [ ] sleep apnea / CPAP
- [ ] reflux / heartburn
- [ ] stomach ulcers
- [ ] colitis
- [ ] Crohn's disease
- [ ] hepatitis / liver disease
- [ ] kidney disease
- [ ] arthritis
- [ ] chronic pain
- [ ] gout
- [ ] fibromyalgia
- [ ] osteomyelitis
- [ ] osteoporosis
- [ ] anemia
- [ ] bleeding disorder
- [ ] blood clots
- [ ] HIV / AIDS
- [ ] MRSA / VRE
- [ ] poor circulation
- [ ] cancer
- [ ] depression
- [ ] drug / alcohol problem
- [ ] psychiatric illness
- [ ] pregnancy (current)
- [ ] other / details

**Surgical History:** [ ] **NONE.** Circle all that apply:

- [ ] Eyes / ENT: cataracts, vision correction, sleep apnea, tonsils, sinus surgery, thyroid, other
- [ ] Heart: bypass, valve replacement, stent, other
- [ ] Lung: resection, other
- [ ] Gastrointestinal: appendix, gall bladder, hernia, other
- [ ] Gynecologic: C-section, hysterectomy, tubal ligation, other
- [ ] Urologic: prostate, bladder, vasectomy, other
- [ ] Orthopaedic: joint replacement, arthroscopy, fracture surgery, spine, other
- [ ] Vascular: carotid, aneurysm, bypass, other
- [ ] Neurosurgical: aneurysm, tumor, craniotomy, other
- [ ] Cancer: skin, breast, thyroid, other
- [ ] Other:

**Anesthesia Complications:** [ ] **NONE.** If yes, explain: ________________________________

**Would you accept blood products or blood transfusions as needed at the discretion of your provider?** [ ] yes [ ] no

**Medications:** [ ] **NONE** [ ] additional sheet attached [ ] Are you taking any blood thinners? [ ] Have you taken chronic steroids?

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<th>Medication</th>
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**Medical Allergies:** [ ] **NONE** [ ] penicillin [ ] sulfa [ ] latex [ ] metals [ ] tape [ ] iodine (IV contrast) [ ] shellfish
[ ] poultry products [ ] anti-inflammatories [ ] other ________________________________

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**In order to establish a complete understanding of the financial**
Social History:
Alcohol Use: [ ] none [ ] occasional [ ] weekly [ ] daily
Tobacco Use: [ ] none [ ] previous When did you quit? [ ] current packs / day: [ ]
Recreational Drug Use: [ ] none [ ] previous [ ] current drug: [ ] Last used?

Fall Assessment:
Have you fallen 2 or more times in the past year? [ ] yes [ ] no Have you seen anyone regarding your fall? [ ] yes [ ] no
Have you had any falls with injury in the past year? [ ] yes [ ] no

Other Current Symptoms: (within the last 4 weeks) [ ] NONE. Circle all that apply:
[ ] yes [ ] no Constitutional: unexpected weight loss, weight gain, fever, chills, night sweats, fatigue
[ ] yes [ ] no Eyes: blurred /double vision, eye pain, redness, watering
[ ] yes [ ] no ENT: headache, difficulty swallowing, nose bleeds, ringing in ears, earaches
[ ] yes [ ] no Cardiovascular: chest pain, palpitations, fainting, murmurs
[ ] yes [ ] no Respiratory: shortness of breath, wheezing, coughing, painful breathing, snoring
[ ] yes [ ] no Gastrointestinal: heartburn, nausea, constipation, incontinence, diarrhea, bloody/black stools
[ ] yes [ ] no Genitourinary: urinary frequency, urgency, difficulty, pain, bleeding, incontinence
[ ] yes [ ] no Musculoskeletal: other joint pains, swelling, instability, stiffness, redness, heat, muscle pain
[ ] yes [ ] no Skin: skin changes, poor healing, rash, itching, redness, foot ulcers
[ ] yes [ ] no Neurological: numbness /tingling, unsteady gait, dizziness, tremors, seizures
[ ] yes [ ] no Psychological: nervousness, anxiety, depression, hallucinations, confusion
[ ] yes [ ] no Hematologic: easy bleeding, bruising
[ ] yes [ ] no Endocrine: excessive thirst or urination, heat / cold intolerance

Family History (mother / father / siblings): [ ] NONE OF THE BELOW
[ ] anesthesia complications [ ] heart disease [ ] high blood pressure
[ ] arthritis [ ] bleeding disorder/blood clots [ ] kidney disease [ ] cancer
[ ] diabetes [ ] other

Occupation:
My duties consist of:
Sitting: _______ hours    Standing: _______ hours    Lifting: _______ pounds    Repetitive Motion: [ ] yes [ ] no
Are you presently working? [ ] yes [ ] no If no, when was your last date worked?
Will your employer allow you to return to work with restrictions? [ ] yes [ ] no
If unemployed explain why:

Patient or Responsible Party Signature: __________________________ Date: __________
Provider Signature: __________________________ Date: __________

Updated Signatures (if hx changed)
Patient or Responsible Party Signature: __________________________ Date: __________
Provider Signature: __________________________ Date: __________