Name:

DOB:

Date:

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?

Medication (include over the counter medicines and nutritional supplements)	**Dose and Frequency**
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

Medical Allergies: ☐ **NONE** ☐ penicillin ☐ sulfa ☐ latex ☐ metals ☐ tape ☐ iodine (IV contrast) ☐ shellfish ☐ poultry products ☐ anti-inflammatories ☐ other ________

Name:

DOB:

Date:

Social History:

Alcohol Use: ☐ none ☐ occasional ☐ weekly ☐ daily

Tobacco Use: ☐ none ☐ previous When did you quit?__________ ☐ current packs / day: __________

When did you start? __________

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 __________
☐yes	☐ no	Other:	__________

Family History (mother / father / siblings): ☐ **NONE OF THE BELOW**

☐anesthesia complications __________	☐ heart disease __________
☐arthritis __________	☐ high blood pressure __________
☐bleeding disorder/blood clots __________	☐ kidney disease __________
☐cancer __________	☐ thyroid disease __________
☐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: