NORTHWEST ORTHOPAEDIC SPECIALISTS

NWOrthopaedicSpecialists.com

Health History

Date: _____

Name: _____ ☐ Male ☐ Female Date of Birth: ____ / ____ / ____

Chief Complaint: ☐ Right ☐ Left Body Part: _____ Current Height: _____ Current Weight: _____

Pharmacy: *Please provide us with the name and location of your pharmacy.*
Pharmacy Name: _____ Location: _____

Allergies: ☐ None known *or Do you have reactions to any of the following? Describe.*

☐ Penicillin: _____ ☐ Codeine: _____ ☐ Latex: _____
☐ Sulfa: _____ ☐ Oxycodone: _____ ☐ Tapes: _____
☐ Iodine Contrast: _____ ☐ Hydrocodone: _____ ☐ Other: _____

Current Medications: *Include the dose and how often the medication is taken (Include Over the Counter Products, Supplements, and Nicotine Patches). If insufficient space, please use back side of page.*

LIST ALL BELOW ☐ See Attached/Scanned List *OR* ☐ Not Taking Any Medications

Vaccines: COVID-19 vaccine: ☐ No ☐ Yes, date(s) _____ Influenza (flu) immunization: ☐ No ☐ Yes, date _____
Pneumococcal (pneumonia) vaccine: ☐ No ☐ Yes, date _____

Family History (include relationship): ☐ None

☐ Blood Coagulation Disorder: _____ ☐ Diabetes: _____
☐ Heart disease: _____ ☐ Malignant hyperthermia: _____
☐ Osteoporosis: _____ ☐ Pulmonary embolism: _____
☐ Complications of anesthesia, describe: _____
☐ Other (specify): _____

Personal/Social History:

Are you: ☐ Left handed ☐ Right handed
Relationship Status: ☐ Unknown ☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Separated ☐ Widowed
Residence: ☐ Live Alone ☐ With Others: _____ Children: ☐ No ☐ Yes How many?: _____
Employed: ☐ No ☐ Yes Occupation: _____ Do you have an Advanced Directive: ☐ No ☐ Yes
Smoking / Tobacco History: ☐ Never smoked ☐ Former smoker. How long ago did you quit? _____
☐ Current every day smoker ☐ Current some day smoker
☐ Smoking how much? _____ Years used? _____
E-cigarettes / Vape: ☐ Never ☐ Former ☐ Current Years used? _____
Smokeless Tobacco: ☐ Never ☐ Former ☐ Chews tobacco or other type: _____ Years used? _____
Has tobacco cessation counseling been provided: ☐ No ☐ Yes Date complete? _____
Alcohol Consumption: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy
Illicit or Recreational Drugs: ☐ No ☐ Yes If yes, please describe: _____
Exercise Level: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Surgical History

Please describe below any orthopaedic surgeries. Include the procedure, side (left or right), and the year.

Foot / Ankle: _____
Hand / Wrist: _____
Hip: _____
Knee: _____
Shoulder: _____
Spine: _____
Other Orthopaedic Surgeries: _____

Please mark or list any other surgeries you have had in the past, including the date:

- ☐ Appendectomy: _____
- ☐ Hysterectomy: _____
- ☐ Hernia: _____
- ☐ Tonsillectomy: _____
- ☐ Oophorectomy: _____
- ☐ Mastectomy: _____
- ☐ Gallbladder: _____
- ☐ C-section: _____
- ☐ Varicose Veins: _____
- ☐ Bypass/Heart surgery: _____
- ☐ Angioplasty/Stent: _____
- ☐ Pacemaker: _____

Other surgeries not listed above: _____

_____

Past Medical History ☐ **No Illnesses** *(Please check all that apply)*

- ☐ Anxiety
- ☐ CVA (Stroke)
- ☐ Depression
- ☐ Dizziness
- ☐ Frequent headaches
- ☐ Mental/Nervous disorder
- ☐ Narcolepsy
- ☐ Prior nerve injury
- ☐ Seizures/Epilepsy
- ☐ Paresthesia lower extremity
- ☐ Parkinson's
- ☐ Diabetes
- ☐ Thyroid dysfunction
- ☐ Bleeding disorder
- ☐ Blood clots (DVT)
- ☐ Blood transfusion
- ☐ Chest pain
- ☐ Heart disease
- ☐ Heart murmur
- ☐ Irregular rhythm
- ☐ MI (Heart attack)
- ☐ MVP (Mitral Valve Prolapse)
- ☐ Poor leg circulation
- ☐ Pressure ulcers
- ☐ AIDS/HIV
- ☐ C-Diff ☐ Active infection
  - ☐ Successfully treated
- ☐ Hepatitis ☐ A ☐ B ☐ C
- ☐ MRSA
- ☐ Tuberculosis
- ☐ Peptic ulcer disease
- ☐ Ulcers/Reflux
- ☐ Fractures, List types:___ _____
- ☐ Chronic back/neck pain
- ☐ Dentures/Partials
- ☐ Bladder/Kidney infection
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Frequent cough
- ☐ Pneumonia
- ☐ Sleep apnea
  - ☐ CPAP ☐ BiPAP
- ☐ Pulmonary embolism
- ☐ Shortness of breath
- ☐ Sleep disorder
- ☐ Cancer
- ☐ Psoriasis
- ☐ General Anesthesia - has had
  - ☐ Caused Nausea/Vomiting
- ☐ Malignant hyperthermia
- ☐ Other: _____ _____

Review of Symptoms: *(Please check all that apply within the last 30 days)*

Constitutional: ☐ **None**
- ☐ Fever
- ☐ Night sweats
- ☐ Significant weight gain
- ☐ Significant weight loss
- ☐ Exercise intolerance
- ☐ Chills
- ☐ Malaise (general feeling of discomfort)

Cardiovascular: ☐ **None**
- ☐ Chest pain/pressure
- ☐ Shortness of breath while walking
- ☐ Shortness of breath while lying down
- ☐ Palpitations
- ☐ Heart murmur
- ☐ Ankle swelling

Respiratory: ☐ **None**
- ☐ Cough
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Sleep apnea
  - ☐ CPAP ☐ BiPAP

Gastrointestinal: ☐ **None**
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Change in appetite
- ☐ GERD

Genitourinary Problems:
- ☐ **None**
- ☐ Incontinence
- ☐ Difficulty urinating
- ☐ Increased frequency of urination

Musculoskeletal: ☐ **None**
- ☐ Muscle aches
- ☐ Muscle weakness
- ☐ Joint pain
- ☐ Back pain
- ☐ Swelling of extremities
- ☐ Neck pain
- ☐ Difficulty walking
- ☐ Cramps
- ☐ Osteoporosis
- ☐ Fractures

Integumentary (Skin): ☐ **None**
- ☐ Rash
- ☐ Laceration
- ☐ Non-healing areas
- ☐ Psoriasis

Neurologic: ☐ **None**
- ☐ Weakness
- ☐ Numbness/Tingling
- ☐ Seizures
- ☐ Gait dysfunction

Psychological: ☐ **None**
- ☐ Depression
- ☐ Alcohol abuse
- ☐ Anxiety
- ☐ Memory loss
- ☐ Dementia

Circulation Problems: ☐ **None**
- ☐ Excessive bleeding
- ☐ Anemia
- ☐ Phlebitis

X _____

Patient Signature Date

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