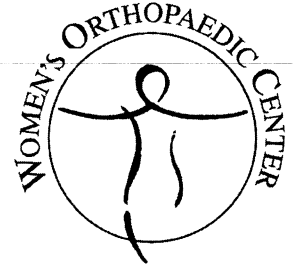


# Health History Form



Patient Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_



**Please explain your reason/s for today's visit:**

\_\_\_\_\_

**YOUR PAST SURGERIES:**

**YEAR:**

**COMPLICATIONS (if any):**


Have you ever had any problems with anesthesia? \_\_\_\_\_ If yes, explain: \_\_\_\_\_

## REVIEW OF SYSTEMS Do you or have you had problems with (your) :

Lungs, Breathing	NO	YES	Polio	NO	YES	Balance Problems	NO	YES
Digestion, Ulcers	NO	YES	Other Orthopaedic Issues	NO	YES	Cancer	NO	YES
Bowel Movements	NO	YES	Kidney Disease	NO	YES	Blackouts, Fainting	NO	YES
Bladder Problems	NO	YES	Seizures, Stroke	NO	YES	Bleeding Problems, Blood Clots	NO	YES
Diabetes	NO	YES	Appetite or weight change	NO	YES	High Cholesterol	NO	YES
Thyroid	NO	YES	Auto-immune Diseases or disorders	NO	YES	High Blood Pressure	NO	YES
Heart Problems,	NO	YES	Arthritis or Osteoarthritis	NO	YES	Depression or Psychological Concerns	NO	YES
Chest Pain	NO	YES						

Approximate height \_\_\_\_\_  
 Approximate weight \_\_\_\_\_

**Describe any *significant* family history of illness: (i.e. Cancer, Diabetes, Heart disease, etc.)**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(OVER)

List all current medications, vitamins and/or natural supplements: (include dosage if, if known)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List any drug allergies: \_\_\_\_\_

\_\_\_\_\_

### SOCIAL HISTORY

Do you live alone?      NO      YES

Employment:      Occupation: \_\_\_\_\_      STUDENT      RETIRED      UNEMPLOYED      DISABLED

Exercise:      NEVER      RARELY      WEEKLY      DAILY      Activity Type: \_\_\_\_\_

Smoke or Chew Tobacco:      NO      YES      Amount per day \_\_\_\_\_ for \_\_\_\_\_ years

Drink Alcohol:      NO      YES      How much and how often? \_\_\_\_\_

History of Substance Abuse:      NO      YES      If yes, please list what chemical(s): \_\_\_\_\_

### WOMEN'S HEALTH CONSIDERATIONS (This section is for female patients only)

Type of Diet: (i.e. Vegan, meat, etc.) \_\_\_\_\_

Amount of milk products or Calcium intake per day: \_\_\_\_\_ servings

Age of onset of menstrual period: \_\_\_\_\_ Do you have regular periods? \_\_\_\_\_ Menopause? \_\_\_\_\_

Do you have Osteopenia or Osteoporosis? \_\_\_\_\_

Have you had a Bone Density/ Dexa scan? \_\_\_\_\_ If yes, when and where? \_\_\_\_\_

History of Eating Disorders? \_\_\_\_\_

Do you have any other concerns you would like to talk to one of our healthcare professionals about? (Such as abuse issues)

\_\_\_\_\_

PATIENT SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

REVIEWED BY \_\_\_\_\_

DATE \_\_\_\_\_

PROVIDER SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_