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)

Revised 01/2011

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**_____