

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 _____

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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: _____