Good Samaritan Medical Group Orthopaedics- Health History

Patient Name:____________________________ | Left Handed Right Handed | Date: _______________

DOB:_______________ Age:_________ Male / Female Height:_______ Weight:___________

Occupation:

History:

Reason for Visit: Left Right Bilateral

ankle arm back clavicle elbow pelvis rib wrist

foot hand hip knee leg neck shoulder other___________

Was this the result of a work or auto injury?

Yes No Date of Injury__________

How and when did the problem start?

Pain Scale (circle one number) No Pain 1 2 3 4 5 6 7 8 9 10 Severe Pain

For this related problem, have any tests been done?

X-rays __________ CT Scan ___________ MRI ___________ EMG ___________ Other ___________

If so, where and when?____

Have any treatments been done for this problem?____

Past Medical History / Review of Systems: (please check EVERY item)

Angina, heart failure or attack	Yes___	No____	Arthritis; What type?________________	Yes___	No____
Heart Valve Problem	Yes___	No____	Osteoporosis	Yes___	No____
High Blood Pressure	Yes___	No____	Thyroid Disorders	Yes___	No____
Irregular Heartbeat	Yes___	No____	Stomach Ulcers	Yes___	No____
Anemia	Yes___	No____	Intestinal Bleeding	Yes___	No____
Blood Transfusion	Yes___	No____	Kidney/Bladder Infections	Yes___	No____
Bleeding Disorder	Yes___	No____	Difficulty Urinating	Yes___	No____
Blood Clots/Phlebitis	Yes___	No____	Sleep Apnea	Yes___	No____
Asthma/Shortness of Breath	Yes___	No____	Hearing Loss	Yes___	No____
Emphysema/Chronic Bronchitis	Yes___	No____	Visual Loss or Glaucoma	Yes___	No____
Pneumonia	Yes___	No____	Recent Weight Gain or Loss (circle one)	Yes___	No____
Hepatitis	Yes___	No____	Depression	Yes___	No____
Tuberculosis	Yes___	No____	Anxiety	Yes___	No____
Cancer; If yes, what type?______________	Yes___	No____	Chemical Dependency/Alcoholism	Yes___	No____
Diabetes; if yes, what type?____________	Yes___	No____	Infection in any joint	Yes___	No____
Seizures	Yes___	No____	If yes, which joint?________________		
Stroke	Yes___	No____	Any other medical problems? (please list)		

Family History: circle and add family member with history (ie: paternal/maternal grandfather, brother, aunt, etc.)

Cancer Family member:____
Goiter Family member:____
Heart Disease Family member:____
High Blood Pressure Family member:____
Bleeding Tendency Family member:____
Kidney Disease Family member:____
Stroke Family member:____
Diabetes Family member:____
Other_______________ Family member:____

Patient signature:________________________ Physician signature:_______________________ Date:________

Patient Information:

Patient Name:	DOB:
Pharmacy:	Pharmacy Phone #:
Date of Last Tetanus Shot:	Are you allergic to latex? Yes No

User of:

Tobacco Yes No	Alcohol Yes No	Illegal Drugs Yes No
History tobacco use Yes No	Frequency: _____________	What type:__________________

Have you or anyone in your family (mother, father, sister, brother) ever had a reaction to anesthestic, general or local, causing high fever (malignant hyperthermia), blood pressure problems, hepatitis, or any other types of allergic reaction? Yes_____ No_____ If yes, please explain:____

Allergies: (Please list)

____

____

Medications: (Please list all prescription, non-prescription, birth control, and herbals)

Generic/Brand Name of Prescription	Dosage (mg)	Generic/Brand Name of Prescription	Dosage (mg)

Surgeries: (Please list all past surgeries) Please indicate right, left or bilateral if applicable.

Surgery Name	Date of Surgery	Hospital Performed At (Name, City, State)	Surgeon's Name

Please continue on back of form if needed