General Health History

DMOS ORTHOPAEDIC CENTERS

Date: _____

Name: _____ Date of Birth: _____ Sex: ☐ M ☐ F

Personal Physician: _____ Referring Physician: _____

Preferred Pharmacy & Location: _____

Illnesses ☐ None

- ☐ Sleep Apnea
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Diabetes
- ☐ Asthma
- ☐ Pneumonia
- ☐ Emphysema
- ☐ Other Illnesses _____
- ☐ Blood Clots
- ☐ Ulcer
- ☐ Anemia
- ☐ Seizures
- ☐ Liver Disease
- ☐ Hepatitis
- ☐ Gout
- ☐ Fibromyalgia
- ☐ Rheumatoid Arthritis
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Stroke
- ☐ Cancer
- ☐ HIV

Orthopaedic Surgeries ☐ None

JOINT REPLACEMENT

R	L		YEAR
☐	☐	Shoulder	_____
☐	☐	Hip	_____
☐	☐	Knee	_____
☐	☐	Elbow	_____
☐	☐	Other_____	_____

JOINT SCOPE

R	L		YEAR
☐	☐	Shoulder	_____
☐	☐	Hip	_____
☐	☐	Knee	_____
☐	☐	Elbow	_____
☐	☐	Wrist	_____

ORTHOPAEDIC SURGERY

R	L		YEAR
☐	☐	Carpal Tunnel Release	_____
☐	☐	Trigger Finger Release	_____
☐	☐	Fracture Repair	_____
	☐	Neck Surgery	_____
	☐	Back Surgery	_____

☐ ☐ Other Orthopaedic Surgeries _____

Surgeries ☐ None

- ☐ Appendectomy
- ☐ Tonsillectomy
- ☐ Gallbladder
- ☐ Hernia Repair
- ☐ Heart Surgery
- ☐ Heart Catheterization or Stent
- ☐ Coronary Artery Bypass
- ☐ Pacemaker
- ☐ Lower Extremity Bypass
- ☐ Cesarean Section
- ☐ Hysterectomy
- ☐ Prostate Surgery
- ☐ Surgical Wound Infections
- ☐ Anesthesia Complications

☐ Other Surgeries _____

Prescription Medications ☐ None

DRUG NAME	DOSE	DRUG NAME	DOSE
1. _____	_____	6. _____	_____
2. _____	_____	7. _____	_____
3. _____	_____	8. _____	_____
4. _____	_____	9. _____	_____
5. _____	_____	10. _____	_____

Over-the-counter ☐ None

DRUG NAME	DOSE	DRUG NAME	DOSE
1. _____	_____	3. _____	_____
2. _____	_____	4. _____	_____

CONTINUED

Medical Allergies ☐ None

	REACTION	OTHER:	REACTION
☐ Penicillin		☐	
☐ Sulfa		☐	
☐ Latex		☐	

Social History

Occupation: _____

Describe your living situation: ☐ Independent ☐ Assisted ☐ Nursing Home

Do you live with someone who can assist you if needed? ☐ Yes ☐ No

Y	N		AMOUNT
☐	☐	Alcohol	_____ Drinks per day
☐	☐	Coffee	_____ Cups per day
☐	☐	Smoking	_____ Packs per day for ____ Years
☐	☐	Chewing Tobacco	_____ Years

Family History

Y	N		RELATION	Y	N		RELATION
☐	☐	Bleeding Disorders		☐	☐	Heart Disease	
☐	☐	Blood Clots		☐	☐	Anesthesia Complications	

Other: _____

Current Symptoms - *Please check yes or no*

Y	N		Y	N		Y	N	
☐	☐	Recent Weight Loss	☐	☐	Heartburn	☐	☐	Anxiety
☐	☐	Fever	☐	☐	Difficulty Swallowing	☐	☐	Claustrophobia
☐	☐	Blurred Vision	☐	☐	Jaundice	☐	☐	Depression
☐	☐	Difficulty Hearing	☐	☐	Painful Urination	☐	☐	Excessive Thirst
☐	☐	Hoarseness	☐	☐	Blood in Urine	☐	☐	Cold Sensitivity
☐	☐	Chest Pain	☐	☐	Rash	☐	☐	Morning Joint Stiffness
☐	☐	Shortness of Breath	☐	☐	Open Non-Healing Sores	☐	☐	Joint Pain
☐	☐	Rapid or Irregular Heartbeat	☐	☐	Excessive Bruising	☐	☐	Joint Swelling
☐	☐	Difficulty Breathing	☐	☐	Numbness in Arms or Legs	☐	☐	Soft Tissue Swelling
☐	☐	Wheezing	☐	☐	Seizures			

Briefly describe your current orthopaedic problem and it's location, duration of symptoms, history of trauma, and previous treatments tried:

[DO NOT WRITE BELOW LINE - FOR OFFICE USE ONLY]

REVIEWED AND UPDATED	PHYSICIAN	DATE
F1000 R110CT16		

Please fill out and bring to your appointment. Thank you!