orthopedics of oregon

Orthopedic Health History

Health History
Entered By: _____
Date: ___/____/_____
For Office Use Only

Today's Date: _____ Appointment Date: _____

Name: _____ Date of Birth: _____
Age: _____ Email: _____

Referring Physician: _____ PCP/Family Doctor: _____

Pharmacy: _____

Emergency Contact and Relationship: _____ Phone: _____

Reason for Visit: (Include Side) _____ Date of Injury/Onset: _____

CURRENT MEDICATIONS: *If you are not currently taking any medications, please check:*
☐ **NONE** ☐ **SEPARATE MEDICAL SHEET IS ATTACHED**
(Include OTC vitamins and supplements)

Medication	**Dose**	**Directions (sig)**

ALLERGIES: ☐ **NONE**
☐ Latex ☐ Tape ☐ Iodine/Betadine ☐ Birds ☐ Feathers ☐ Eggs

Medication Allergies: **Reaction:**

MEDICAL HISTORY: ***Please check all that apply or check*** ☐ **NONE**

☐ Alzheimer's or Dementia
☐ Anemia
☐ Anesthetic Problems
List:_____
☐ Arthritis
☐ Asthma
☐ Deep Vein Thrombosis

☐ Cancer: _____
☐ Congestive Heart Failure
☐ COPD (lung disease)
☐ Coronary Artery Disease

☐ Depression
☐ Diabetes- Type: _____
☐ Drug Abuse
Type: _____
☐ High Cholesterol
☐ Fibromyalgia
☐ Fractures (body part and side):
_____
☐ Gout
☐ Hepatitis: ____ (type)
☐ Hypertension (high bp)
☐ Liver Disease

☐ Myocardial Infarction
☐ Osteoporosis
☐ Peptic Ulcer
☐ Seizure Disorder
☐ CPAP
☐ Sleep Apnea
☐ Stroke (CVA)

☐ Systemic Lupus
☐ Thyroid Disease
☐ Valvular Disease
☐ Other

SURGICAL HISTORY: *Please check all that apply and indicate side and site*

☐ **No Surgical History**

Type of Surgery	**Side**	**Site**	**Date**
☐ Amputation (what body part?)	☐ **R** ☐ **L**		
☐ Angioplasty			
☐ Arthroscopy (What Kind?)	☐ **R** ☐ **L**		
☐ Back Surgery (What kind?)			
☐ Coronary Artery Bypass Graft			
☐ Cardiac Pacemaker			
☐ Cardiac Valve Replacement			
☐ Carpal Tunnel Release	☐ **R** ☐ **L**		
☐ Defibrillator			
☐ Gall Bladder Removal			
☐ Gastric Bypass			
☐ Hip Replacement	☐ **R** ☐ **L**		
☐ Hysterectomy			
☐ Knee Replacement	☐ **R** ☐ **L**		
☐ Mastectomy			
☐ ORIF/Fractures (with surgery)			
☐ Thyroidectomy			
☐ Other Surgeries			

FAMILY HISTORY: *Please check all that apply or check* ☐ **NONE or** ☐ **ADOPTED**

Father ☐ NONE	Mother ☐ NONE	Brother ☐ NONE	Sister ☐ NONE
☐ Arthritis _____	☐ Arthritis _____	☐ Arthritis _____	☐ Arthritis _____
☐ Blood Disorder	☐ Blood Disorder	☐ Blood Disorder	☐ Blood Disorder
☐ Cancer _____	☐ Cancer _____	☐ Cancer _____	☐ Cancer _____
☐ Diabetes	☐ Diabetes	☐ Diabetes	☐ Diabetes
Type: _____	Type:_____	Type: _____	Type: _____
☐ Heart Disease	☐ Heart Disease	☐ Heart Disease	☐ Heart Disease
☐ Osteoporosis	☐ Osteoporosis	☐ Osteoporosis	☐ Osteoporosis
	☐ Other _____	☐ Other _____	☐ Other _____

SOCIAL HISTORY:

Tobacco Use:

☐ **Yes** ☐ **No** ☐ **Former**

Tobacco Type:	**Use Daily:**	**Usage/day:**	**Years Used:**	**Age Started:**	**Age Stopped:**	**Units/year if applicable:**
☐ Cigarette	☐ Y ☐ N	_____Units	_____	_____	_____	_____ packs
☐ Chewing	☐ Y ☐ N	_____Units	_____	_____	_____	_____ units
☐ Pipe	☐ Y ☐ N	_____Units	_____	_____	_____	_____ units
☐ e-Cig	☐ Y ☐ N	_____Units	_____	_____	_____	_____ units

Alcohol: ☐ Yes ☐ No

Type: _____ Amount & Frequency:_____

Caffeine: ☐ Yes ☐ No

Type: _____ Amount & Frequency:_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Hand Dominance: ☐ Right-handed ☐ Left-handed ☐ Ambidextrous

Activity Level: ☐ Sedentary ☐ Moderate ☐ Vigorous

Exercise Frequency: ☐ Never ☐ Occasional ☐ 2-3 times/wk ☐ 3-4 times/wk ☐ Daily

Occupation: _____ Employer: _____