orthopedics of oregon

HEALTH HISTORY
Entered by: _____
Date: ____/____/____
FOR OFFICE USE ONLY

ORTHOPEDIC HEALTH HISTORY

Today's Date:_____

Name *(please print)*:_____ Date of Birth:_____ Age:_____

Do you have an advanced directive? ☐ Yes ☐ No *(If yes, please bring a copy to your appointment.)*

Email Address:_____ Phone:_____

Referring Physician:_____ PCP/Family Doctor:_____

List Specialty Providers *(Cardiologist, Pulmonologist, etc.)*:_____

Pharmacy:_____

Emergency Contact
and Relationship:_____ Phone:_____

Reason for Visit
(include site):_____ Date of Injury/Onset
of Symptoms:_____

CURRENT MEDICATIONS: Please list all medication including over-the-counter, vitamins, and herbal supplements.

☐ *Check this box if you do NOT take any medications* ☐ *Check if separate medical sheet is attached* ☐ *Check if on a PAIN CONTRACT with Dr.* _____

Medication	Dose	Directions (sig)

ALLERGIES: ☐ **NONE**

☐ Latex - *Reaction?*_____ ☐ Tape - *Reaction?*_____ ☐ Iodine/Betadine - *Reaction?*_____
☐ Birds - *Reaction?*_____ ☐ Feathers - *Reaction?*_____ ☐ Eggs - *Reaction?*_____

MEDICATION ALLERGIES & REACTION:

_____

_____

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

☐ Alzheimer's *(dementia)*
☐ Anemia
☐ Anesthetic Problems
list: _____
☐ Arthritis: _____
☐ Asthma
☐ Deep Vein Thrombosis
☐ Cancer: _____
☐ Congestive Heart Failure
☐ COPD *(lung disease)*
☐ Coronary Artery Disease
☐ COVID *(Have you been diagnosed in the past?)*
Received COVID vaccine? ☐ Yes ☐ No
☐ Depression
☐ Diabetes - Type: _____
☐ Drug Abuse
☐ High Cholesterol *(elevated lipid)* _____
☐ Fibromyalgia
☐ Fractures *(indicate body part & side)*
_____
☐ Gout
☐ Hepatitis/liver disease _____
☐ Hypertension *(high blood pressure)*
☐ Malignant Hyperthermia
☐ Myocardial Infarction
☐ Osteoporosis
☐ Peptic Ulcer
☐ Seizure Disorder
☐ Sleep Apna ☐ CPAP
☐ Stroke *(CVA)*
☐ Systemic Lupus
☐ Valvular Disease
☐ Other _____

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ORTHOPEDIC HEALTH HISTORY

SURGICAL HISTORY: *Please check all that apply and indicate side, site and date or check* ☐ **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 - Type: _____	☐ Diabetes - Type: _____	☐ Diabetes - Type: _____	☐ Diabetes - Type: _____
☐ Gout	☐ Gout	☐ Gout	☐ Gout
☐ Heart Disease	☐ Heart Disease	☐ Heart Disease	☐ Heart Disease
☐ Osteoporosis	☐ Osteoporosis	☐ Osteoporosis	☐ Osteoporosis
☐ Other	☐ Other	☐ Other	☐ Other

SOCIAL HISTORY:

Tobacco Use: ☐ **No** ☐ Former
☐ Chew ☐ Cigarettes ☐ Cigar ☐ ePipe Type: _____ Amount/Day: _____ Years/Use: _____

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

If you are 65 and older, have you fallen in the last 12 months? ☐ Yes ☐ No
If yes, number of falls: _____ Did the fall(s) result in injury? ☐ Yes ☐ No *(If yes, type:_____)*

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

Occupation: _____ **Employer:** _____