Patient History Form

PREMIER Bone & Joint Centers

A Registered Trade Name of Gem City Bone & Joint, P.C.

Name: _____ Date of Birth _____

BP _____ WT _____ HT _____

Allergies: please list all allergies including medications, food, and anything environtmental

Allergy	Reaction	Allergy	Reaction

✧✧Does your skin break out when exposed to: Metal Y N Latex Y N

Medications: Please list ALL current medications you are taking including vitamins, herbals, etc.

Medication	Dose and Frequency	Medication	Dose and Frequency

Health History Please check yes or no. If yes, please explain (including date if possible)

• Cardiac	Yes or No	
Heart Disease	Y N	
Chest Pain	Y N	
Heart Attack	Y N	
Irregular Heartbeat	Y N	
Pacemaker	Y N	
High Blood Pressure	Y N	
Cardiac Stent (s) Placed/Bypass	Y N	When?
• **Hematologic**		
Anticoagulation / Blood Thinner	Y N	
Recent Aspirin use	Y N	
Recent Anti-inflammatory use	Y N	
Bleeding Problems	Y N	
Blood Clots	Y N	
Blood Transfusion	Y N	
• **Respiratory**		
Sleep Apnea	Y N	
Use a CPAP / BiPAP	Y N	
Asthma	Y N	
Wheezing	Y N	
Bronchitis	Y N	
Pneumonia	Y N	
Emphysema	Y N	
COPD	Y N	
Current oxygen use at home	Y N	How many liters?

Health History Continued

Please check yes or no. If yes, please explain (including date if possible)

• **Neurologic**	**Yes or No**	
Epilepsy / Seizures	**Y N**	
Severe Headaches / Migraines	**Y N**	
Stroke	**Y N**	
Spinal Cord Injury	**Y N**	
Other: please specify below	**Y N**	
• **Endocrine**		
Diabetes	**Y N**	
Thyroid Disease	**Y N**	
Cortisone/Steroid use in past year	**Y N**	
• **Renal**		
Kidney Disease	**Y N**	
Prostate Problems	**Y N**	
Could you be pregnant	**Y N**	
• **GI / Hepatic**		
Liver Disease	**Y N**	
Hepatitis	**Y N**	
Jaundice	**Y N**	
Indigestion	**Y N**	
Special Diet	**Y N**	
• **Skeletal**		
Arthritis	**Y N**	
Rheumatoid or Inflammatory	**Y N**	
Gout	**Y N**	
Broken bones in the past	**Y N**	Please list/Explain:
Neck Problems	**Y N**	
Back Problems	**Y N**	
Any current physical restrictions	**Y N**	
• **Psychologic**		
Mental Illness / Depression	**Y N**	
Do you suffer from PTSD?	**Y N**	
• **Other**		
Cancer	**Y N**	
HIV Positive / AIDS	**Y N**	
Chronic Infections (i.e. MRSA)	**Y N**	
Recent weight loss	**Y N**	

Surgical/Hospitalization History **(include dates and facilities if possible)**

Date	Surgery / Hospitalization	Facility	Problems with Anesthesia?

Review of Systems (have you had any of the following symptoms in the last few months)

Fevers	Y	N	Joint Pain	Y	N
Vision Problems	Y	N	Skin Infections / Problems	Y	N
False / capped / loose teeth	Y	N	Balance Problems	Y	N
Swelling of Extremities	Y	N	Mood Problems	Y	N
Recent cough, cold, or sore throat	Y	N	Night Sweats	Y	N
Diarrhea / Nausea / Vomiting	Y	N	Bruise Easily	Y	N
Difficulty with Urination	Y	N	Hayfever or other allergies	Y	N

Social History

Tobacco Use	Y N	Start Date?	Stop Date?	How much?	Cigarette?	Pipe?	Chew?
Alcohol use and amount	Y N	Start Date?	Stop Date?	How much?			
Do you use street drugs	Y N	Start Date?	Stop Date?	How much?	Type?		
Have you had the flu shot	Y N	Date?					
Have you had a pneumonia shot	Y N	Date?					

Do you have a nickname of prefer to go by a different name:

What do you do for a living:

Who is your Primary Medical Doctor and what is their phone number: _____	Who is your emergency contact and their phone number: _____
What Pharmacy do you prefer to use and city:	Do you have an Advanced Directive: Y N * If so, please provide a copy for your chart

Family Medical History (include person affected - Maternal / Paternal)

Major Medical Problem		Relationship to patient
Any blood relatives having trouble with anesthesia? e.g. Malignant Hyperthermia	Y N	Relative(s): _____

Other Pertinent Information (e.g. Lupus, MS, etc.) _____

_____

_____

_____

DISCLAIMER: I UNDERSTAND THAT QUESTIONS NOT ANSWERED WILL BE CONSIDERED NO, NONE, OR NOT APPLICABLE.

Patient Signature: _____ Date: _____

Reviewed By / Date: _____ Reviewed By / Date: _____