# Patient History Form

PREMIER Bone & Joint Centers

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

**Patient Name:** _____ **DOB:** _____

BP _____ WT _____ HT _____ BMI _____

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

| 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 |
|---|---|---|---|
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## 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? |

**Patient Name:** _____ **DOB:** _____

## 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? |
|---|---|---|---|
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**Patient Name:** _____ **DOB:** _____

## 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 | Hay fever 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? | | |

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

What do you do for a living:

| | |
|---|---|
| Who is you Primary Medical Doctor and 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**<br>* If so, please provide a copy for your chart |

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

| Major Medical Problem | Relationship to patient |
|---|---|
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|---|---|---|
| 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: _____

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