SRO Santa Rosa Orthopaedics
Expertise. Care. Healing

Patient History Form

Patient Information

Name: _____ Today's Date: _____/_____/_____

Height:_____ **Weight**: _____ lbs. D.O.B._____/_____/ _____ Age:_____ Sex: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Single ☐ Children How many?_____

Employment /Occupation:_____ ☐ Student ☐ Retired ☐ Unemployed

Medications

If none, please check here ☐

Please list ALL medications you are taking (include prescription, over-the-counter and/or herbal and nutritional supplements).

Pharmacy:_____ (If more room is needed, use "Comments" at end of form.)

Name: _____ Dosage: _____ Name: _____ Dosage: _____

Name: _____ Dosage: _____ Name: _____ Dosage: _____

Name: _____ Dosage: _____ Name: _____ Dosage: _____

Name: _____ Dosage: _____ Name: _____ Dosage: _____

Do you take any blood thinners (i.e. Coumadin, Plavix, aspirin, etc.)? ☐ Yes ☐ No If yes, please describe: _____

_____

Have you had any problems with anesthesia? ☐ Yes ☐ No If yes, please explain:_____

_____

Allergies

Please check all that apply: If none, please check here ☐

☐ Medications (i.e. betadine, iodine, etc.). Please list ALL medications you are allergic to:_____

_____

☐ Foods. Please list ALL foods you are allergic to:_____

_____

☐ Latex Allergy ☐ Tape Allergy ☐ Seasonal Allergies

Past Medical History

Please check all that apply: If none, please check here ☐

Could you be pregnant? ☐ Yes ☐ No **If yes, make sure no X-rays are taken!**

- ☐ AIDS or HIV
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bladder Infections
- ☐ Blood Clot / DVT
- ☐ Bronchitis
- ☐ Cancer (Type:_____)
- ☐ Diabetes
- ☐ Epilepsy / Seizures
- ☐ Gastric Reflux
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Attack
- ☐ Hemophilia
- ☐ Hepatitis (A, B, or C)
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Polio
- ☐ Psoriasis
- ☐ Pulmonary Embolus
- ☐ Renal Failure
- ☐ Rheumatic Fever
- ☐ Rheumatoid Arthritis
- ☐ Scoliosis
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcer

Surgeries/Serious Illnesses

Please list all prior surgeries or serious illnesses. If none, please check here ☐

Date: _____ Surgery/Illness: _____ Hospitalized? ☐ Yes ☐ No

Date: _____ Surgery/Illness: _____ Hospitalized? ☐ Yes ☐ No

Date: _____ Surgery/Illness: _____ Hospitalized? ☐ Yes ☐ No

Date: _____ Surgery/Illness: _____ Hospitalized? ☐ Yes ☐ No

Patient Name: _____

Family History

☐ No known family history. Or, please check box where applicable:

	Father	Mother	Brother	Sister	Son	Daughter
Rheumatoid Arthritis	☐	☐	☐	☐	☐	☐
Breast Cancer	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
Diabetes Mellitus	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐

Please explain any other family history of significant medical problems:

_____

_____

Social History

Do you drink alcohol? ☐ Yes ☐ No If yes, how many times per: Day____ Week____ Month____

Do you smoke? ☐ Never ☐ Quit ☐ Yes
If yes, how often?_____

History of substance abuse? ☐ Yes ☐ No
If yes, which substances (chemical, recreational drug, prescription drug, alcohol)? _____

_____

_____

Review of Systems

Check all that apply: If none, please check here ☐

Systemic:
- Weight change ☐
- Chills ☐
- Fever ☐
- Night sweats ☐
- Feeling tired/poorly ☐

Head:
- Headache ☐
- Eyesight problems ☐
- Nosebleeds ☐

Neck:
- Neck pain ☐
- Neck stiffness ☐
- Lump or swelling ☐

Pulmonary:
- Shortness of breath ☐
- Cough ☐
- Coughing up blood ☐
- Wheezing ☐

Cardiovascular:
- Chest pain or discomfort ☐
- Fast heart rate ☐
- Palpitations ☐

Gastrointestinal:
- Difficulty swallowing ☐
- Heartburn ☐
- Nausea ☐
- Vomiting ☐
- Abdominal pain ☐
- Diarrhea ☐

Genitourinary:
- Blood in urine ☐
- Painful urination ☐
- Increased urinary frequency ☐

Skin:
- Itching/scratching ☐
- Skin lesions ☐
- Rash ☐

Endocrine:
- Excessive sweating ☐
- Excessive thirst ☐

Hematological:
- Easy bleeding ☐
- Easy bruising ☐

Neurological:
- Dizziness ☐
- Vertigo ☐
- Motor disturbances ☐
- Sensory disturbances ☐

Psychological:
- Sleep disturbances ☐
- Anxiety ☐
- Depression ☐

Cancer (Type):_____

_____

Additional Comments:_____

_____

_____

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be hazardous to my health. It is my responsibility to inform the doctor of any changes in my medical status. I also authorize the health care staff of Santa Rosa Orthopaedics to perform the necessary services I may need.

Signature of Patient or Parent of Minor:_____Date: _____

Reviewed by Physician: _____Date: _____