SANTA ROSA ORTHOPAEDICS

Patient History Form

Today's Date: ____ / ____ / ____

Patient's Name (Last, First, Middle Initial)

Patient's Height: _____ Weight: _____lbs. D.O.B.: ____ / ____ _____ Age: ____ Sex: ◯ Male ◯ Female

Marital Status: ◯ Married ◯ Divorced ◯ Separated ◯ Widowed ◯ Single ◯ Children _____

Employment / Occupation: _____ ◯ Student ◯ Retired ◯ Unemployed

Please list ALL Medications you are taking (Include prescription, over the counter and/or herbal & nutritional supplements) If none, Please check here ☐ None

Drug Name	Dosage	Drug Name	Dosage

(**If more space is needed, see added comments at end of form

Do you have any allergies? ◯ Yes ◯ No

Medications: (i.e., allergic to certain medications, betadine, iodine, etc.)
If yes, list ALL medications you are allergic to _____

Foods: (Allergic reactions to any foods.) If yes, please list ALL foods you are allergic to _____

Do you have: Latex Allergy: ◯ Yes ◯ No Tape Allergy: ◯ Yes ◯ No

Do you take any blood thinners? (i.e., Coumadin, Plavix, aspirin, etc.) ◯ Yes ◯ No
(if Yes, please describe) _____

Past Medical History

Have you ever had any of the following? Please check all pertinent boxes. If none, Please check here ☐ None
Could you be pregnant? ◯ Yes ◯ No (If "YES", MAKE SURE NO X-RAYS ARE TAKEN!)

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

Please list all prior Surgeries or Serious Illness:

Date	Surgery / Illness	Hospitalized?	Date	Surgery / Illness	Hospitalized?

Patient's Name (Last, First, Middle Initial)

Have you had any problems with anesthesia? ◯ Yes ◯ No
(if Yes, please describe) _____

Family Health History

Any Family history of significant Medical Problems? ◯ Yes ◯ No (If yes, please describe)

Social History

Do you drink alcohol? ◯ Yes ◯ No Daily # _____ Weekly # _____ Monthly # _____ Yearly # _____
Do you Smoke: ◯ Never ◯ Previously, but quit ◯ Currently, if so how much _____
History of substance abuse? (i.e., Alcohol, chemical dependency, recreational drug use, etc.) ◯ Yes ◯ No
Which substances? _____

Review of Systems:

If none, Please check here ☐ None

Systemic symptoms:
Weight Change ☐ Yes
Chills ☐ Yes
Fever ☐ Yes
Night sweats ☐ Yes
Feeling tired/poorly ☐ Yes

Head:
Headache ☐ Yes
Eyesight problems ☐ Yes
Nosebleeds ☐ Yes

Neck symptoms:
Neck pain ☐ Yes
Neck Stiffness ☐ Yes
Lump Or Swelling in neck ☐ Yes

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

Cardiovascular symptoms:
Chest pain or discomfort ☐ Yes
Fast heart rate ☐ Yes
Palpitations ☐ Yes

Gastrointestinal symptoms:
Difficulty Swallowing ☐ Yes
Heartburn ☐ Yes
Nausea ☐ Yes
Vomiting ☐ Yes
Abdominal pain ☐ Yes
Diarrhea ☐ Yes

Genitourinary symptoms:
Blood in urine ☐ Yes
Painful urination ☐ Yes
Increased urinary frequency ☐ Yes

Skin symptoms:
Skin Itch / scratch ☐ Yes
Skin lesions ☐ Yes
Rash ☐ Yes

Endocrine symptoms:
Excessive sweating ☐ Yes
Excessive thirst ☐ Yes

Hematological symptoms:
Easy bleeding ☐ Yes
Easy bruising ☐ Yes

Neurological symptoms:
Dizziness ☐ Yes
Vertigo ☐ Yes
Motor disturbances ☐ Yes
Sensory disturbances ☐ Yes

Psychological symptoms:
Sleep disturbances ☐ Yes
Anxiety ☐ Yes
Depression ☐ Yes

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: _____, M.D. Date: _____