Azalea Orthopedic & Sports Medicine Clinic
HEALTH HISTORY

Name ______________________ Age ________ Were you referred by a Physician? Yes ________ No ________
Who requested our services? ______________________ Family Physician ______________________
Reason for seeking medical attention ______________________ Right Left Both
Date of injury or duration of symptoms ____________ Work related? __________ Yes ____ No Are you right or left handed? Right Left
Have you had any diagnostic studies for this condition, such as MRI, Bone Scan, etc? Please list ______________________
Have you seen anyone else regarding this condition? Yes ___________ No _____ If yes, list names and dates ______________________

Have you ever been diagnosed with any of the following medical conditions:

	Yes	No		Yes	No		Yes	No
Asthma	_____	_____	Rheumatoid Arthritis	_____	_____	Osteoarthritis	_____	_____
Kidney Disease	_____	_____	Anemia	_____	_____	Alcoholism	_____	_____
Lupus	_____	_____	Migraines	_____	_____	Sickle Cell Disease	_____	_____
Bleeding Tendencies	_____	_____	Cancer	_____	_____	Colitis	_____	_____
Heart Disease	_____	_____	Diabetes	_____	_____	Stroke	_____	_____
Epilepsy	_____	_____	Goiter	_____	_____	Stomach Ulcers	_____	_____
High Blood Pressure	_____	_____	Lung Disease	_____	_____	Depression/Anxiety	_____	_____
Polio	_____	_____	Nervous System Disorder	_____	_____	COPD (Chronic Obstructive Pulmonary Disease)	_____	_____
Hepatitis	_____	_____	Tuberculosis	_____	_____			

Other Medical Conditions: ______________________
Are there law suits pending on your orthopedic condition? ______________________

Please list any orthopedic surgeries and dates:

____
____
____
____
____

Please list any other surgeries and dates:

____
____
____
____
____

Please list all current medications and dosages:

______________________ ______________________ ______________________
______________________ ______________________ ______________________
______________________ ______________________ ______________________

Are you allergic to: *(check if you are)*

- ☐ Latex ☐ Penicillin ☐ Cephalosporin ☐ Mycins ☐ Sulfa ☐ Tetanus ☐ Iodine
- ☐ Dyes ☐ Aspirin ☐ Codeine ☐ Morphine ☐ Adhesive Tape ☐ Arthritis Medicines

Foods (please list): ______________________
Others: ______________________

Do you currently use tobacco: ☐ cigarettes ☐ pipe ☐ smokeless amount per day: ____________ Quit when? ____________
Do you drink alcohol: ☐ beer ☐ liquor ☐ wine amount per day: ____________ or per week: ____________
What is your current occupation: ______________________

Has anyone in your family had:

- ☐ High Blood Pressure ☐ Heart Disease ☐ Cancer (*If yes, what type of cancer?*) ______________________ ☐ Diabetes
- ☐ Bleeding Problems ☐ Lung Disease

Have you recently had any of the following problems or symptoms:

	Yes	No		Yes	No		Yes	No
Chest Pain	_____	_____	Irregular Heart Beat	_____	_____	Fainting Spells	_____	_____
Breathing Difficulties	_____	_____	Cough	_____	_____	Cough with Blood	_____	_____
Numbness or Tingling	_____	_____	Dizziness	_____	_____	Headaches or Migraines	_____	_____
Vision Changes	_____	_____	Fever or Chills	_____	_____	Unexpected Weight Loss	_____	_____
Abdominal Pain	_____	_____	Nausea or Vomiting	_____	_____	Diarrhea	_____	_____
Bloody or Black Tarry Stools	_____	_____	Loss of Control of Bowels	_____	_____	Difficulty Starting Urine	_____	_____
Pain or Burning on Urination	_____	_____	Blood in Urine	_____	_____	Loss of Control of Bladder	_____	_____

Patient's Signature ______________________ Physician's Signature ______________________ Date ____________
(I have reviewed this information with the patient)

FOR OFFICE USE ONLY

Height_______ Weight_______ BP_______ Pulse_______

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