AZALEA ORTHOPEDICS
PAST FAMILY & SOCIAL HISTORY

SOCIAL HISTORY								
Alcohol: Never Social Frequent Type: Quit? / When:								
Drug Use: Never Frequent Occasional Past Type:								
Exercise Level: None Occasional Moderate Heavy								
Marital Status: Single Married Divorced Widowed								
Tobacco Use: Never Current Smoker Pack(s) a Day: Quit? / When:								
IMMEDIATE FAMILY MEDICAL HISTORY: (Please specify relation) (Please circle all that apply)								
High Blood Pressure	YES	NO	Diabetes	YES	NO	Heart Trouble	YES	NO
Respiratory Problems	YES	NO	Stroke	YES	NO	Cancer	YES	NO
Bleeding Problems	YES	NO	HIV / AIDS	YES	NO	Other Problems:	YES	NO
PATIENT MEDICAL HISTORY (Please circle yes or no for the following)								
CONSTITUTIONAL			**GASTROINTESTINAL**			**NEUROLOGICAL**		
Good General Health	YES	NO	Nausea / Vomiting	YES	NO	Frequent Headaches	YES	NO
Fever	YES	NO	Abdominal Pain	YES	NO	Paralysis	YES	NO
Night Sweats	YES	NO	Rectal Bleeding	YES	NO	Numbness / Tingling	YES	NO
Fatigue	YES	NO				Stroke	YES	NO
EYES / EARS / NOSE / THROAT			**GENITOURINARY – M/F**			**PSYCHIATRIC**		
Contact Lenses	YES	NO	Blood in Urine	YES	NO	Trouble Sleeping	YES	NO
Wear Glasses	YES	NO	Problems Urinating	YES	NO	Confusion	YES	NO
Blurred / Double Vision	YES	NO	Testicle Pains	YES	NO	Memory Loss	YES	NO
Hearing Loss	YES	NO	**MUSCULOSKELETAL**			**ENDOCRINE**		
Ringing in Ears	YES	NO	Muscle Pains/Cramps	YES	NO	Excessive Thirst / Urination	YES	NO
Frequent Nose Bleeds	YES	NO	Stiff / Swelling Joints	YES	NO			
Sore Throat /Voice Change	YES	NO	Joint Pains	YES	NO	**HEMATOLIC**		
Sinus Problems	YES	NO	Back Pain	YES	NO	Bruise Easily	YES	NO
CARDIOVASCULAR			**INTEGUMENTARY (Skin/Breast)**			Slow to Heal	YES	NO
Chest Pains	YES	NO	Change in Moles/Bump	YES	NO	Enlarged Glands	YES	NO
Swelling Hands / Feet	YES	NO	Change in Hair / Nail	YES	NO	Blood Problems	YES	NO
Palpitations	YES	NO	Rashes / Itching	YES	NO	**LIVER**		
Lightheaded	YES	NO	Breast Discharge	YES	NO	Enlargement	YES	NO
RESPIRATORY						Cirrhosis	YES	NO
Sleep Apnea	YES	NO						
Shortness of Breath	YES	NO						
Cough	YES	NO						
Coughing up Blood	YES	NO						
Abdominal Problems	YES	NO	Depression	YES	NO	Kidney Stones /Disease	YES	NO
Anesthesia Problems	YES	NO	Diabetes	YES	NO	Lung Disease	YES	NO
Asthma	YES	NO	Esophagitis	YES	NO	Menstrual Problems	YES	NO
Bleeding Problems	YES	NO	Eye Disease /Glaucoma	YES	NO	Muscle Disease	YES	NO
Blood Clots	YES	NO	Gerd	YES	NO	Neurologic Disease	YES	NO
Bowel Problems	YES	NO	GI Disease	YES	NO	Psychiatric Disease	YES	NO
Breast Lumps / Pain	YES	NO	Good General Health	YES	NO	Significant Weight Change	YES	NO
Bronchitis	YES	NO	Heart Disease	YES	NO	STD	YES	NO
Cancer	YES	NO	Hepatitis	YES	NO	Stroke	YES	NO
Cataracts	YES	NO	HIV / AIDS	YES	NO	TB	YES	NO
Convulsions / Seizures	YES	NO	Hormone Abnormalities	YES	NO	Trouble Walking	YES	NO
Coronary Artery Disease	YES	NO	Hypertension	YES	NO	Thyroid Disease	YES	NO
						Wound Healing Problems	YES	NO

PATIENT STATEMENT: "To the best of my knowledge, the above information is accurate and complete."

Signature: _____ Date: _____

OFFICE USE ONLY: Date: _____ HT: _____ WT: _____ BP: _____ BMI: _____