

St. Croix Orthopaedics – Health History

Name: _____ Age: _____

Allergies: (Medication, latex, metal)	Type of reaction:	<input type="checkbox"/> No Known Allergies

Have you or a family member ever had any reaction to anesthesia? Yes No

Medical History

Illnesses (Diabetes, Heart Disease, etc.)	Date Diagnosed	Past Surgeries	Date

List current medications with dosages: _____

Have you or your immediate family (parents, siblings) ever been diagnosed with any of the following conditions?
Please check those that apply to you or a family member.

Family History **PS**=Personal/self **M**=Mother **F**=Father **S**=Sibling **C**=Child **MGP**=Maternal grandparent
PGP=Paternal grandparent **NA**=Not applicable **Adopted**=Medical history unknown

Condition	Who	Condition	Who	Condition	Who
Heart disease		Diabetes		Emphysema	
Kidney disease		Stroke		Seizures / epilepsy	
Bleeding problems		Psychiatric problems		Arthritis	
High blood pressure		Glaucoma		Liver problems / hepatitis	
Anemia		Stomach ulcers		Chemical dependency	
Leukemia		Lung disease		Breast cancer	
Thyroid disorder		Tuberculosis		Liver cancer	
AIDS or HIV		Lymphoma		Ovarian cancer	
Melanoma		Bone cancer		Other cancer	

Do you currently or have you recently had any of the following symptoms (please check those that apply):

- | | | |
|---------------------------------------------------------|----------------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Awaken short of breath | <input type="checkbox"/> Arm pain |
| <input type="checkbox"/> Fevers / chills / night sweats | <input type="checkbox"/> Cough on exertion | <input type="checkbox"/> Back pain |
| <input type="checkbox"/> Lightheadedness | <input type="checkbox"/> Coughing up blood | <input type="checkbox"/> Leg pain |
| <input type="checkbox"/> Sudden weight gain or loss | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Swollen legs |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Nausea / heartburn | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Loss of consciousness |
| <input type="checkbox"/> Loss of circulation | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Rash |
| <input type="checkbox"/> Anxiety / nervousness | <input type="checkbox"/> Loss of bladder / bowel control | <input type="checkbox"/> Sleep Apnea |

What is your occupation? _____ Right or left-handed? _____

Are you currently working? _____ Do you drink alcohol? _____ How much? _____ Do you smoke? _____ How much? _____

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Date	Initials	Date	Initials	Date	Initials

Reviewed / updated (DATE AND INITIAL). Make notations of any changes throughout form. (Office use only)

St. Croix Orthopaedics – Current Condition

Name _____ DOB _____

Primary Physician _____

My problem/condition today is: _____

The problem/condition began (date): _____

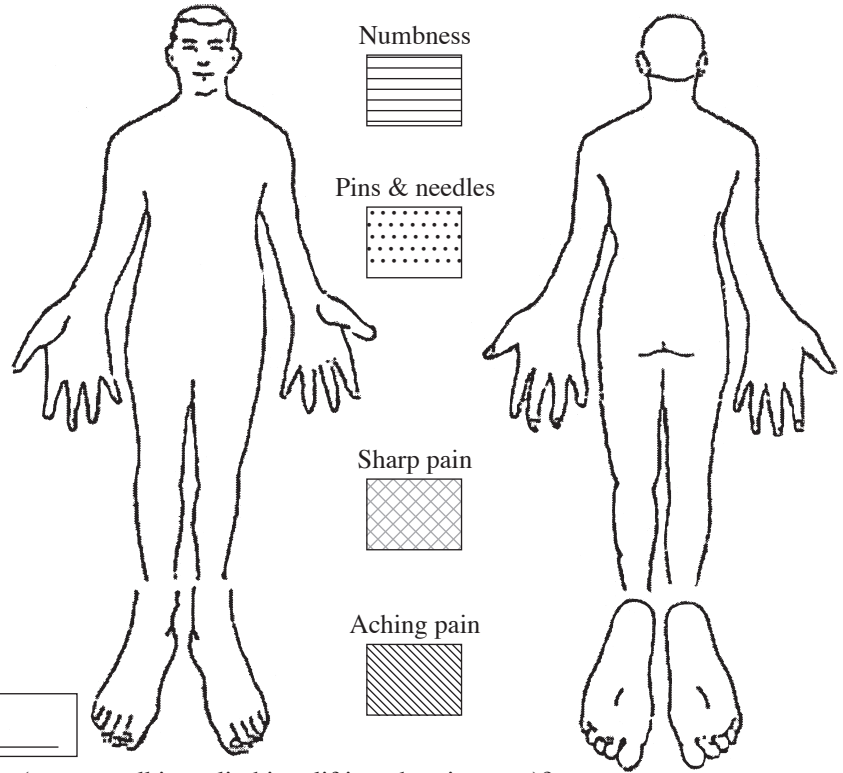
This problem/condition occurred (work, home, etc.): _____

This problem/condition was caused by (accident/sports, overuse, etc.): _____

Please check the tests / treatments completed:

Test or treatment	Date	Result
<input type="checkbox"/> X-rays	_____	_____
<input type="checkbox"/> Bone scan	_____	_____
<input type="checkbox"/> CT scan	_____	_____
<input type="checkbox"/> MRI scan	_____	_____
<input type="checkbox"/> EMG/NCS	_____	_____
<input type="checkbox"/> Discogram	_____	_____
<input type="checkbox"/> Myelogram	_____	_____
<input type="checkbox"/> Arthrogram	_____	_____
<input type="checkbox"/> Decreased activity	_____	_____
<input type="checkbox"/> Ice or heat	_____	_____
<input type="checkbox"/> Therapy	_____	_____
<input type="checkbox"/> Chiropractic	_____	_____
<input type="checkbox"/> Braces	_____	_____
<input type="checkbox"/> Anti-inflammatories	_____	_____
<input type="checkbox"/> Other medication	_____	_____
<input type="checkbox"/> Injections	_____	_____
<input type="checkbox"/> Other	_____	_____

Please mark the areas of your body with the appropriate symbol where you feel the symptoms described below:



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Height _____ Weight _____ BP _____

What activities are limited at present due to your condition (sports, walking, climbing, lifting, dressing, etc.)?

Please check (✓) the answer that best describes your **most recent** condition related to the **“Part affected.”**

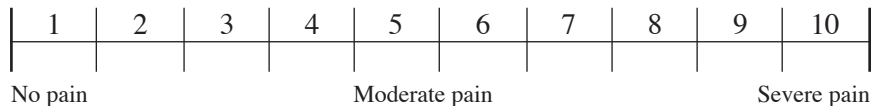
The **resting pain** in my _____ is: Severe Moderate Mild Minimal None

The **activity pain** in my _____ is: Severe Moderate Mild Minimal None

The **frequency of pain** in my _____ is: Constant Frequent Occasional Infrequent None

The **function** of my _____ is: Awful Poor Fair Good Normal

On a scale of 1-10, please rate your pain:



Patient Signature _____ Date _____

Provider Signature _____ Date _____