Washington Orthopaedics and Sports Medicine, P.A. **Patient Health History**

Today's Date: _____ **Update #1:** _____ **Update #2:** _____

Name: _____ **Age:** _____ **Date of Birth:** _____

Gender: _____ **Height:** _____ **Weight:** _____

Primary Care Physician: _____ **Date Last Seen:** _____

Cardiologist: _____ **Date Last Seen:** _____

Other Physician(s): _____ **Date Last Seen:** _____

Hand Dominance: ☐ Right ☐ Left **Last Tetanus Shot or Booster:** / / ; / /

Medication and Dosage- Please list or update any medications you take, including dosage.

☐ No Medications Actively Being Taken (Only complete if updating list)

Medication Name:	Dosage:	Currently Active		No Longer Active
		☐		☐
		☐		☐
		☐		☐
		☐		☐
		☐		☐
		☐		☐
		☐		☐
		☐		☐
		☐		☐
		☐		☐
		☐		☐
		☐		☐
		☐		☐
		☐		☐

Allergies

☐ No Known Drug Allergies

Surgical History

Prior Surgeries	When	Any Complications?

Family History (Close, Blood, Relatives) - Please check all that apply				
☐Heart Disease	☐Diabetes	☐Cancer	☐Thyroid Disease	☐Neurological
☐High Blood Pressure	☐Tuberculosis	☐Kidney Disease	☐Blood Disease	☐Mental Illness

Social History				
☐Employed (Occupation) _____			☐Work at Home	☐Student
☐Single	☐Married	☐Divorced	☐Separated	☐Widowed
Do you live alone? ☐Yes ☐No		Do you have children? ☐No ☐Yes Number: _____		
Exercise? ☐Daily ☐Weekly ☐Monthly ☐Rarely ☐Never			☐Low ☐Moderate ☐Active	
Smoke Currently? ☐No ☐Yes ____ Packs/day for _____ years			Drink Alcohol? ☐Daily	☐1-2x/week
Quit Smoking? ☐This Year ☐> 1 year ☐>5 years ☐>10 years			☐1-2x/month	☐1-2x/year
Previously Smoked _____ packs per day for _____ years			☐No Alcohol	

Review of Systems - *Check all that apply*			
Bleeding/Circulation	**Cancer or Tumor**	**Endocrine**	**Genitourinary**
☐Anemia	☐Type _____	☐Diabetes	☐Kidney Disease
☐Bleeding Tendency	☐Chemo _____	Circle: Diet / Pill / Insulin / Pump	☐Kidney Stones
☐Blood Clots	☐Radiation _____	☐Liver Disease	☐Prostate/Testicle Problem
☐Poor Circulation	☐Skin-Basal/Squamous	☐Thyroid Problems/Goiter	☐Urinary Tract Infection
☐Sickle Cell	☐Other _____	☐Adrenal Disease	☐Difficulty Urinating
☐None	☐None	☐None	☐None
Cardiac	**Neurological/Mental Health**	**Infectious Diseases**	**Respiratory**
☐Chest Pain	☐Stroke	☐Recent Mono	☐Asthma
☐Congestive Heart Failure	☐Stroke Mini (TIA)	☐HIV	☐Bronchitis
☐Heart Disease	☐Seizures	☐Hepatitis	☐Difficulty Breathing
☐High Cholesterol	☐Migraine Headaches	☐MRSA	☐Emphysema/COPD
☐High Blood Pressure	☐Chemical Dependency	☐VRE	☐Hoarseness
☐Pulmonary Hypertension	☐Myasthenia Gravis	☐C Diff	☐Pneumonia
☐Pacemaker/ICD (Bring	☐Depression/Anxiety	☐None	☐Sleep Apnea
your implant card with you)	☐Emotional Illness	☐Treating Physician?	☐CPAP-Y / N ?
☐Rheumatic Heart	☐Claustrophobia	_____	☐Smoking
☐Rhythm Disturbances	☐Panic Attack		☐History of Smoking
☐Irregular Heart Beats	☐Learning Disabilities		☐Neck Size _____ inches
☐None	☐None		☐TB
			☐None
Implantable Devices	**Gastrointestinal**	**Musculoskeletal**	**Hearing & Vision**
☐Ports/Pumps	☐Recurrent Gastric Reflux	☐Arthritis	☐Hearing Loss
☐Pacemaker/ICD	☐Hernia	☐Circle: Osteo or Rheumatoid	☐Hearing Aide
☐Other	☐Ulcers	☐Gout	☐Glasses
(list)_____	☐Difficulty Swallowing	☐Multiple Sclerosis	☐Contacts
_____	☐None	☐Polio	☐Glaucoma
☐None		☐Osteopenia	☐Cataract
Important! Bring implant card with you to the hospital		☐None	☐None

Breast		**Skin**
☐Lumps	☐Abnormal Mammogram	☐Rashes, Where?_____
☐Breast Pain	☐Nipple Discharge	☐Sores/Open Areas ☐None
	☐None	

Have you been hospitalized for any of the above conditions? When?_____ Where?_____
Briefly Explain:

Anesthesia?	es	NO	?	plain
Have you ever had anesthesia?	☐	☐	☐	
Have you ever had a problem with anesthesia including malignant hyperthermia or difficult intubation?	☐	☐	☐	
Has any member of your family had a problem with anesthesia?	☐	☐	☐	
Loose, capped, or broken teeth, bridges or dentures?	☐	☐	☐	
Trouble opening mouth or jaw clicking?	☐	☐	☐	
Do you have shortness of breath after walking up 2 flights of stairs?	☐	☐	☐	
Do you use any street drugs?	☐	☐	☐	
Have you ever had a blood transfusion?	☐	☐	☐	If yes, what year(s)?
Do you have objections to receiving blood transfusions?	☐	☐	☐	
Do you have problems with chronic pain?	☐	☐	☐	
Any religious /cultural practices we should know about?	☐	☐	☐	

Please note Only complete this section if instructed to do so by WOSM staff

Update #1

I have reviewed my health history and confirm that that information listed is complete, correct, and/or I have made the necessary changes to update my health information.

Signature _____ Date _____

Please note Only complete this section if instructed to do so by WOSM staff

Update #2

I have reviewed my health history and confirm that that information listed is complete, correct, and/or I have made the necessary changes to update my health information.

Signature _____ Date _____

Office se Only Patient Status: ☐ Healthy ☐ Medically Managed Stable ☐ Major Co-Morbidities

MD Signature _____ Date _____

MD Signature _____ Date _____

MD Signature _____ Date _____