Name:
DOB:
Chart:
Age:
Date:

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Medication Name:	Dosage:	Currently Active		No Longer Active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?

Name:
DOB:
Chart:
Age:
Date:

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 your implant card with you)	☐ Depression/Anxiety	☐ None	☐ Sleep Apnea
	☐ 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 (list)_____ _____	☐ Ulcers	☐ Gout	☐ Glasses
	☐ 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:

Name:
DOB:
Chart:
Age:
Date:

Anesthesia?	Yes	NO	?	Explain
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?	☐	☐	☐	

Do you have an advanced directive? ☐Yes ☐No

****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 Use Only: Patient Status: ☐ Healthy ☐ Medically Managed Stable ☐ Major Co-Morbidities

MD Signature: _____ **Date:** _____

MD Signature: _____ **Date:** _____

MD Signature: _____ **Date:** _____