**UNM Orthopaedics Health History**

 \*\*\*This form will become part of your medical record. Please

**Patient Name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of REFERRING medical provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| Do you have, or have you ever had, any of the following **MEDICAL PROBLEMS:** | Circle your answer: | List details to these or any **OTHER** Medical Problems you have or have had: |
| Heart attackHigh blood pressureHigh cholesterolDiabetesStrokeAsthmaEmphysema/COPDUlcers/RefluxRheumatoid arthritisGoutSeizures/EpilepsyThyroid diseaseHepatitisHIV/AIDSCancer | YES NOYES NOYES NOYES NOYES NOYES NOYES NOYES NOYES NOYES NOYES NOYES NOYES NOYES NOYES NO |  |
| List any **DRUG ALLERGIES:** |
|  |
| Circle any of the following if you are ALLERGIC:Iodine IV Contrast Shellfish Latex |
| List any **MEDICATIONS**  you are taking: |
|  |  |
| **SOCIAL HISTORY:**Are you employed? YES NOOccupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date last worked:\_\_\_\_\_\_\_\_\_\_\_\_\_\_Do or did you ever smoke? YES NO \_\_\_\_\_Packs per day for\_\_\_\_\_\_\_ years Did you quit? YES NO If so, when did you quit?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Other tobacco/nicotine products? YES NO What kind? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Drink alcohol? YES NO How much and how often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_History of illegal drugs/substance abuse? YES NO What kind?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Are you: Single Married Divorced Separated Widowed Do you live alone? YES NODo you Exercise? Never Rarely Weekly Daily What type?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**MD Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Form**

 fill out as accurately as possible.\*\*\*

**Age:**\_\_\_\_\_\_\_ Are you **RIGHT** or **LEFT** handed?

(MD, DO, PA, RNP, chiropractor)

|  |
| --- |
| List any **SURGERIES** you have had and, if known, the **YEAR** and the name of the Surgeon: |
|  |
| **FAMILY HISTORY**Do any of your grandparents, parents or siblings have any of the following: |
| DiabetesHigh blood pressureHeart attackStrokeRheumatoid arthritisBleeding disordersCancer | YES NOYES NOYES NOYES NOYES NOYES NOYES NO |
| **REVIEW OF SYSTEMS:**Do you have NOW, or have you had RECENTLY, problems with any of the following: | Circle your answer: |
| Fevers, chills, weight lossEyesEars, Nose, ThroatTeeth, MouthChest pain, Heart ProblemsShortness of Breath, LungsConstipation, DiarrheaUrinary tract infectionJoint pain, Joint stiffnessSkin rashes, lesionsMigraines, HeadachesBlackouts/FallingBalance problemsPsychological problems/DepressionHigh cholesterolDiabetesBleeding disordersBlood clots, DVTSeasonal allergies | YES NOYES NOYES NOYES NOYES NOYES NOYES NOYES NOYES NOYES NOYES NOYES NO YES NOYES NOYES NOYES NOYES NOYES NOYES NO |
| Patient Label |