Patient Health History

LAST NAME_____ **FIRST NAME**_____**MI**__ **SUFFIX**_____

M_____**F**_____ **AGE**_____**DOB**_____ **Height** _____ **Weight** _____

Primary Care Physician_____

Cardiologist_____

Other Specialist _____

Medical Illnesses

_____aids/HIV	_____Cancer	_____Ulcer	_____Osteoporosis
_____Anemia	_____Cardiac disease	_____Hepatitis	_____Seizures
_____Asthma	_____Diabetes	_____ Hypertension	_____Stroke
_____Bleeding	_____GI	_____Lung Disease	_____Urinary
_____Blood Clots	_____High Cholesterol	_____Endocrine	_____Renal

Other Medical Conditions_____

Surgeries/Hospitalization/Year

_____ _____

_____ _____

_____ _____

Medication/Dosage/ Route (oral, injection, topical etc.)

_____ _____ _____

_____ _____ _____

_____ _____ _____

Allergies/Reaction: _____

Social History

Occupation: _____Marital Status: Single_____Married_____Divorced_____Widowed_____

Do you have children: ___ Yes ___ No Live Alone _____Yes ____No

Do you smoke: ___ Yes ____ No (if yes, how many packs per day _____ for _____ years

Do you drink alcohol: ____ Yes _____ No (if yes average amount per week_____)

Exercise _____Yes ____ No _____ Daily ____ Weekly _____Rarely

If female, are you pregnant, or is there a possibility you may be pregnant: ____ yes _____ No

Family History

Member	Alive	**Age**	Deceased	Pertinent Health Issues	Cause of Death
Father	A		D		
Mother	A		D		
Siblings	A		D		

To the best of my knowledge, the information provided above is correct.
I hereby consent to treatment at the Knee Hip Shoulder Center for stated problems for which I am being seen for today.

Patient signature_____ **Date**_____