Health History

SUBMIT FORM

Welcome to Advanced Orthopaedic Associates

Patient Name: _____ Birth Date: _____ Height: _____ Weight: _____

Chief Complaint for Appointment: _____

History of Present Illness:

Location: _____
(Where is the pain/problem?)

Quality: _____
(Example: Normal versus abnormal color, activity, etc.)

Severity: _____
(How severe is the pain/problem on scale of 1-10 with 10 as most severe?)

Duration: _____
(How long have you had the pain/problem? When did it start?)

Timing: _____
(Does the pain/problem occur at specific time or continuously?)

Context: _____
(Where were you at the onset of this pain/problem?)

Associated Signs/Symptoms: _____

Modifying Factors: _____

List any treatment to date: _____

Previous Hospitalizations/Serious Illness:	***When***	***Hospital, City, State***

Have you had any falls within the past 12 months? Yes ◯ No ◯ Resulted in injury? Yes ◯ No ◯

Pacemaker? Yes ◯ No ◯ Are you currently pregnant? Yes ◯ No ◯ If so, how many weeks? _____

Use of tobacco? Yes ◯ No ◯ Alcohol use within the past year? Yes ◯ No ◯ Only socially ◯ Heavy ◯

List All Medications *(Include Non-prescription)*: _____

_____

Allergies to Medications: _____

Family Medical History:

Has anyone in your family had any of the following? Advanced Directive? Yes ◯ No ◯

Heart Disease	Yes ◯	No ◯	Hypertension	Yes ◯	No ◯	Stroke	Yes ◯	No ◯
Diabetes	Yes ◯	No ◯	Lung Disease	Yes ◯	No ◯	Other:		
Cancer	Yes ◯	No ◯	Rheumatoid Arthritis	Yes ◯	No ◯	_____		

_____ _____

Signature of Patient, Parent or Guardian Date