

Prairie



Shoulder, Elbow & Hand Center

Patient Name: _____

Date: _____

AGE: _____

HEIGHT _____ WEIGHT _____

HEALTH HISTORY

ONGOING MEDICAL PROBLEMS:

- Arthritis (Type): Yes No _____
- Asthma Yes No _____
- Bronchitis Yes No _____
- Blood Clots Yes No _____
- Blood Transfusions Yes No _____
- Cancer Yes No _____
- Heart Yes No _____
- Constipation Yes No _____
- Depression Yes No _____
- Diabetes Yes No _____
- Diarrhea Yes No _____
- DVT (Deep Vein Thrombosis) Yes No _____
- Emphysema / COPD Yes No _____
- Gastroesophageal reflux Yes No _____
- Gout Yes No _____
- HIV/AIDS Yes No _____
- Hepatitis Yes No _____
- High Blood Pressure Yes No _____
- Kidney disease Yes No _____
- Lung disease Yes No _____
- Prostate Yes No _____
- Ulcers Yes No _____
- Thyroid problem Yes No _____
- Others: _____

Prescription Drugs:

Dosage:

Over the Counter Drugs/Herbal:

Dosage

PREVIOUS SURGERIES:

- Tonsil Appendix Gallbladder
- Cataract Hysterectomy Breast
- Prostate Thyroid

(Please circle side surgery was done on)

- Shoulder Surgery **R / L** Date: _____
- Carpal Tunnel **R / L** Date: _____
- Knee replacement **R / L** Date: _____
- Hip replacement **R / L** Date: _____
- Knee Scope **R / L** Date: _____
- Foot **R / L** Date: _____
- Biopsy of: _____
- Heart: _____
- Other: _____

MEDICATION ALLERGIES: Yes No **What medications?** _____

(WHAT TYPE OF REACTION DO YOU HAVE?) _____

Latex allergy Yes No Adhesives allergy Yes No Metal Allergy Yes No

FAMILY HISTORY: (parents/siblings)

Heart Disease: Yes No (what kind & who has?: _____)

Cancer: Yes No (what kind & who has): _____

Bleeding Tendency Yes No Diabetes Yes No Osteoporosis Yes No

Other: _____

Patient Name: _____

SOCIAL HISTORY:

Education completed: High School GED College Trade School Professional School
 Military Service: Yes No Branch of the armed forces _____ Tour of Duty: _____
 Occupation: _____ Employer: _____ How Long? _____
 Previous Employer: _____ How Long? _____
 Marital Status: Single Married Divorced Separated Widowed Number of Children _____
 Do you use nicotine products? No, never have
 Yes How much? _____ (pack can cigar) per day for ___ years
 No, I stopped on _____ How much did you use? _____ (pack can cigar) per day for _____ years
 Do you use street drugs? Y / N
 How often do you Exercise: daily regularly weekly occasionally not at all
 Usage of Alcohol: not at all rare minimal moderate heavy previous user
 Usage of Caffeine: none minimal moderate heavy

REVIEW OF SYSTEMS

Are you currently experiencing any of the following (**check appropriate problems**)

GENERAL:

___ fever
 ___ chills
 ___ sweats
 ___ recent weight gain
 ___ recent weight loss
 ___ fatigue
 ___ snoring
 ___ sleep disturbance
 ___ anesthesia problems

EYES/EARS/NOSE:

___ vision changes
 ___ contact lenses or glasses
 ___ hearing loss
 ___ nasal congestion
 ___ cough
 ___ runny nose

CARDIAC:

___ chest pain
 ___ palpitations
 ___ racing heart
 ___ ankle swelling

LUNGS:

___ shortness of breath
 ___ wheezing
 ___ coughing blood
 ___ sputum production

GASTROINTESTINAL:

___ abdominal pain
 ___ bloating
 ___ vomiting
 ___ heartburn
 ___ constipation
 ___ diarrhea

GENITOURINARY:

___ urinary frequency
 ___ urinary urgency
 ___ pain with urination

ENDOCRINE:

___ excessive thirst
 ___ excessive urination
 ___ dry skin
 ___ heat/cold intolerance

GYNECOLOGICAL:

___ irregular menstrual cycles
 ___ menopause
 Last menstrual period: _____
 Pregnant? ___ Yes ___ No

SKIN:

___ easy bruising
 ___ rash
 ___ discoloration of skin
 ___ birth marks

LYMPH/BLOOD:

___ lumps or bumps
 ___ easy bruising
 ___ bleeding tendency

NEUROLOGIC:

___ light headed
 ___ dizziness
 ___ seizures
 ___ numbness

PSYCHIATRIC:

___ stress
 ___ depression
 ___ anxiety
 ___ suicidal thoughts

MUSCULOSKELETAL:

___ joint inflammation
 ___ restriction of motion
 ___ swelling
 ___ pain
 ___ muscle pain
 ___ muscle swelling
 ___ difficulty with balance
 ___ walk with limp
 ___ walk with drop foot
 ___ weakness

For Office Use Only: DATE: _____ INITIALS: _____ DATE: _____ INITIALS: _____
 DATE: _____ INITIALS: _____ DATE: _____ INITIALS: _____