The Orthopedic and Spine Institute of St. Louis

HEALTH HISTORY

Name: _____ Phone: _____ Date: _____

DOB: _____ Height: _____ Weight: _____ ☐ Male ☐ Female

Pregnant: ☐ Yes ☐No ☐Unknown Primary Care Physician: _____

Past Medical History: check all that apply

☐ **NO PAST MEDICAL HISTORY**

☐ Adverse reaction to anesthesia
Type of reaction:_____

☐ Asthma

☐ Blood Clot
☐ Legs ☐ Lungs

☐ Cancer type: _____

☐ Cirrhosis

☐ Depression

☐ Diabetes
☐ Type I ☐ Type II

☐ Emphysema / COPD

☐ Fibromyalgia

☐ Gout

☐ Heart Disease

☐ Hemophilia / Bleeding disorders

☐ Hepatitis

☐ Hepatitis

☐ High blood pressure / Hypertension

☐ High cholesterol

☐ HIV or AIDS

☐ Infections: _____
MRSA? ☐ Yes or ☐ No

☐ Kidney disease

☐ Osteoarthritis

☐ Osteoporosis

☐ Psychiatric disorder

☐ Rheumatoid arthritis

☐ Sickle cell

☐ Sleep apnea
☐ CPAP Machine

☐ Stroke

☐ Thyroid disease

☐ OTHER: _____

Surgical History: indicate procedure (body part, left or right) and year ☐ **DENIES SURGERY HISTORY**

_____

_____

_____

Allergies to Medication: ☐ **NO MEDICATION ALLERGIES**

Are you allergic to latex? ☐ Yes ☐ No Tape/Adhesive allergy? ☐ Yes ☐ No

Are you allergic or sensitive to metals/ nickel? ☐ Yes ☐ No

1. _____ Reaction: _____
2. _____ Reaction: _____
3. _____ Reaction: _____
4. _____ Reaction: _____

Name: _____ DOB: _____

Current Medication List: List all medication and use additional sheet if needed.

☐ **NOT CURRENTLY TAKING MEDICATION**

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____

Family History: Check all that apply to immediate relatives and list who.

☐ **NO FAMILY HISTORY TO REPORT** ☐ **ADOPTED**

☐ Cancer
Relation: _____

☐ Diabetes
Relation: _____

☐ Heart Disease
Relation: _____

☐ Hypertension
Relation: _____

☐ Osteoarthritis
Relation: _____

☐ Osteoporosis
Relation: _____

☐ Rheumatoid arthritis
Relation: _____

☐ Stroke
Relation: _____

☐ Other:
_____
_____
_____
_____
_____
_____

Social History:

Marital Status: ☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Widow / Widower

Smoking: ☐ Never smoked ☐ Former smoker ☐ Current smoker - How many packs/day? _____

Do you dip or chew tobacco? ☐ Yes ☐ No If yes, how much per day? _____

Do you drink alcoholic beverages? ☐ Yes ☐ No If yes, how much per day? _____

Do you have a history of alcoholism? ☐ Yes ☐ No Do you have a history of substance abuse ☐ Yes ☐ No

Employment Status: ☐ Employed full-time ☐ Employed part-time ☐ Unemployed ☐ Disabled ☐ Retired

If employed list and describe job duties: _____

_____

_____

Review of systems:

☐ **NO SYMPTOMS TO REPORT**

Abdominal pain: ☐ Y ☐ N

Anxiety: ☐ Y ☐ N

Chest Pain: ☐ Y ☐ N

Changes in bowel or bladder habits: ☐ Y ☐ N

Changes in weight gain or loss: ☐ Y ☐ N

Dizziness: ☐ Y ☐ N

Easy bleeding/bruising: ☐ Y ☐ N

Fever/Chills: ☐ Y ☐ N

Fatigue: ☐ Y ☐ N

Headaches: ☐ Y ☐ N

Heartburn: ☐ Y ☐ N

Shortness of breath: ☐ Y ☐ N

Skin wounds/Rashes: ☐ Y ☐ N

Swollen glands: ☐ Y ☐ N

Vision problems: ☐ Y ☐ N ☐ glasses ☐ contacts ☐ history of Lasik