Salem Health® Hospitals & Clinics

# ORTHOPEDIC HEALTH HISTORY

**HEALTH HISTORY**
Entered by: _____
Date: ____/____/____
***FOR OFFICE USE ONLY***

Today's Date:_____

Name *(please print)*:_____ Date of Birth:_____ Age:_____

Do you have an advanced directive? ☐ Yes ☐ No *(If yes, please bring a copy to your appointment.)*

Email Address:_____ Phone:_____

Referring Physician:_____ PCP/Family Doctor:_____

List Specialty Providers *(Cardiologist, Pulmonologist, etc.)*: _____

Pharmacy:_____

Emergency Contact

and Relationship:_____ Phone:_____

**Reason for Visit**
*(include site)*:_____ Date of Injury/Onset of Symptoms:_____

## CURRENT MEDICATIONS: Please list all medication including over-the-counter, vitamins, and herbal supplements.

☐ *Check this box if you do NOT take any medications* ☐ *Check if separate medical sheet is attached* ☐ *Check if on a PAIN CONTRACT with Dr.* _____

| Medication | Dose | Directions (sig) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## ALLERGIES: ☐ NONE

☐ Latex - *Reaction?* _____ ☐ Tape - *Reaction?* _____ ☐ Iodine/Betadine - *Reaction?* _____
☐ Birds - *Reaction?* _____ ☐ Feathers - *Reaction?* _____ ☐ Eggs - *Reaction?* _____

## MEDICATION ALLERGIES & REACTION:

_____

_____

## MEDICAL HISTORY: *Please check all that apply or check* ☐ NONE

☐ Alzheimer's (dementia)
☐ Anemia
☐ Anesthetic Problems
list: _____
☐ Arthritis: _____
☐ Asthma
☐ Deep Vein Thrombosis
☐ Cancer: _____
☐ Congestive Heart Failure
☐ COPD (lung disease)
☐ Coronary Artery Disease
☐ COVID (Have you been diagnosed in the past?)
Received COVID vaccine? ☐ Yes ☐ No
☐ Depression
☐ Diabetes - Type: _____
☐ Drug Abuse
☐ High Cholesterol (elevated lipid) _____
☐ Fibromyalgia
☐ Fractures (indicate body part & side)
_____
☐ Gout
☐ Hepatitis/liver disease _____
☐ Hypertension (high blood pressure)
☐ Malignant Hyperthermia
☐ Myocardial Infarction
☐ Osteoporosis
☐ Peptic Ulcer
☐ Seizure Disorder
☐ Sleep Apna ☐ CPAP
☐ Stroke (CVA)
☐ Systemic Lupus
☐ Valvular Disease
☐ Other _____

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## SURGICAL HISTORY: *Please check all that apply and indicate side, site and date or check* ☐ NO Surgical History

| Type of Surgery | Side | Site | Date |
|---|---|---|---|
| ☐ Amputation *(what body part?)* | ☐ R ☐ L | | |
| ☐ Angioplasty | | | |
| ☐ Arthroscopy *(what kind?)* | ☐ R ☐ L | | |
| ☐ Back Surgery *(what kind?)* | | | |
| ☐ Coronary Artery Bypass Graft | | | |
| ☐ Cardiac Pacemaker | | | |
| ☐ Cardiac Valve Replacement | | | |
| ☐ Carpal Tunnel Release | ☐ R ☐ L | | |
| ☐ Defibrillator | | | |
| ☐ Gall Bladder Removal | | | |
| ☐ Gastric Bypass | | | |
| ☐ Hip Replacement | ☐ R ☐ L | | |
| ☐ Hysterectomy | | | |
| ☐ Knee Replacement | ☐ R ☐ L | | |
| ☐ Mastectomy | | | |
| ☐ ORIF/Fractures *(with surgery)* | | | |
| ☐ Thyroidectomy | | | |
| ☐ Other Surgeries | | | |

## FAMILY HISTORY: *Please check all that apply or check* ☐ NONE or ☐ ADOPTED

| FATHER ☐ None | MOTHER ☐ None | BROTHER ☐ None | SISTER ☐ None |
|---|---|---|---|
| ☐ Arthritis: _____ | ☐ Arthritis: _____ | ☐ Arthritis: _____ | ☐ Arthritis: _____ |
| ☐ Blood Disorder | ☐ Blood Disorder | ☐ Blood Disorder | ☐ Blood Disorder |
| ☐ Cancer: _____ | ☐ Cancer: _____ | ☐ Cancer: _____ | ☐ Cancer: _____ |
| ☐ Diabetes - Type: _____ | ☐ Diabetes - Type: _____ | ☐ Diabetes - Type: _____ | ☐ Diabetes - Type: _____ |
| ☐ Gout | ☐ Gout | ☐ Gout | ☐ Gout |
| ☐ Heart Disease | ☐ Heart Disease | ☐ Heart Disease | ☐ Heart Disease |
| ☐ Osteoporosis | ☐ Osteoporosis | ☐ Osteoporosis | ☐ Osteoporosis |
| ☐ Other | ☐ Other | ☐ Other | ☐ Other |

## SOCIAL HISTORY:

**Tobacco Use:** ☐ No ☐ Former
☐ Chew ☐ Cigarettes ☐ Cigar ☐ ePipe Type: _____ Amount/Day: _____ Years/Use: _____

**Alcohol:** ☐ Yes ☐ No
Type: _____ Amount & Frequency: _____

**Caffeine:** ☐ Yes ☐ No
Type: _____ Amount & Frequency: _____

**Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed

**Hand Dominance:** ☐ Right-handed ☐ Left-handed ☐ Ambidextrous

**Activity Level:** ☐ Sedentary ☐ Moderate ☐ Vigorous

**If you are 65 and older, have you fallen in the last 12 months?** ☐ Yes ☐ No

If yes, number of falls: _____ Did the fall(s) result in injury? ☐ Yes ☐ No (If yes, type:_____)

**Exercise Frequency:** ☐ Never ☐ Occasional ☐ 2-3 times/wk ☐ 3-4 times/wk ☐ Daily

**Occupation:** _____ **Employer:** _____