NORTHERN
Orthopaedics
a department of Northern Regional Hospital

Patient name: _____ Age: _____ Date of Birth: _____

Sex: M F

Reason for Visit: _____

PAST MEDICAL HISTORY

Have you ever had any of the following:

Check each item	No	Yes	Check each item	No	Yes	Check each item	No	Yes
Aids			Heart Disease			Heart Attack		
Anemia			Depression			Arthritis		
Anxiety			Diabetes			Osteoporosis		
Asthma			Emphysema			Pneumonia		
Back Problems			Fibromyalgia			Kidney Infection		
Blood Clots			Stomach Ulcer			Rheumatoid Arthritis		
Kidney Stones			Hepatitis			Seizures		
Cancer			Hypertension			Steroid Use		
Stroke			Liver Disease			Thyroid Problems		
Gall Stones			Lupus			Tuberculosis		
Chronic Lung Disease			Mitral Valve Prolapse			Bladder Infection		

PAST SURGICAL HISTORY

List any surgeries:_____

MEDICATIONS

List any Medications you are currently taking.

NAME	Strength	How often taken
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

Patient Name:_____

ALLERGIES

List any medication allergies.

Medication	Reaction
1.	
2.	
3.	
4.	
5.	

Are you allergic to Eggs? Yes No Iodine? Yes No Shellfish? Yes No

Are you allergic to any foods?_____

FAMILY HISTORY-Has anyone in your family (blood relative) had the following:

	No	Yes	Family Member		No	Yes	Family Member
Anesthesia Problem				High Blood Pressure			
Bleeding Problem				Osteoporosis			
Cancer				Stroke			
Diabetes				Thyroid Disease			
Heart Disease							

SOCIAL HISTORY

Occupation:_____ Retired ___ Disabled___ Unemployed___

Marital Status: Single___ Married___ Separated___ Divorced___ Widowed___

Do you have any advanced directives?(Living Will, Health Care Power of Attorney, Do Not Resuscitate) If yes, please specify:_____

Are you an Athlete? If yes, what sport?_____

Are you Right Handed Left Handed (circle one)

Preferred Language for discussing your health care:_____

Are you now or have you ever been a victim of domestic violence/abuse?_____

Patient Name:_____

Do You...	No	Yes	Do You...	No	Yes
Regularly exercise (3-4 times weekly)			Use alcohol		
Wear auto seat belt (90% of time)			Smoke (if ever when did you stop?) Stop date:_____ Circle type of smoking: • Cigar smoking, pipe smoking • Dip, chewing tobacco, oral tobacco, snuff, spit tobacco • E-cigarettes, electronic cigarettes, personal vaporizer, vaping		
Use illegal drugs					

REVIEW OF SYSTEMS

Do you have any of the following?

	No	Yes		No	Yes
Fever			Urinary Frequency		
Chills			Painful or difficulty urinating (dysuria)		
Unexplained Weight Loss			Blood in Urine (hematuria)		
Double Vision			Rash		
Vision Changes			Itching		
Headaches			Muscle Weakness		
Nosebleeds			Uncoordinated		
Chest Pain			Tingling or Numbness		
Heart Murmur			Loss of Balance		
Palpitations			Joint Pain		
Shortness of Breath			Muscle Pain		
Wheezing			Back Pain		
Cough			Increase Urination (polyuria)		
Nausea			Increased thirst (polydipsia)		
Vomiting			Anxiety		
Diarrhea			Depression		
Constipation			Easy Bleeding		
Bloody Bowel Movements			Easy Bruising		
Urinary Urgency			Lymph Node Enlargement/Tenderness		

Are you currently under the care of a pain clinic? (If so, where)_____

When was your last Mammogram? _____

When was your last Colonoscopy? _____

When was your last DEXA ? _____