

# **GRAND HAVEN BONE & JOINT MEDICAL HISTORY INFORMATION**

Name \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_\_\_  
 Personal Physician \_\_\_\_\_ Referring Physician \_\_\_\_\_  
 Are you right or left handed? R L Date of Injury or Onset of Symptoms \_\_\_\_\_

**CHIEF COMPLAINT:** (Main reason for being here today)

**MEDICAL HISTORY:**

Do you have any Allergies to Medications?: \_\_\_\_\_  
 Last Tetanus shot: \_\_\_\_\_  
 Current Medications: \_\_\_\_\_  
 Past Surgical Procedures / Dates: \_\_\_\_\_

**Do you have a history of any of the following?**

Yes No	Yes No	Yes No
<input type="checkbox"/> <input type="checkbox"/> High blood pressure	<input type="checkbox"/> <input type="checkbox"/> Bowel disease	<input type="checkbox"/> <input type="checkbox"/> Diabetes
<input type="checkbox"/> <input type="checkbox"/> Neurologic (stroke, seizures, etc.)	<input type="checkbox"/> <input type="checkbox"/> Cancer (Type _____)	<input type="checkbox"/> <input type="checkbox"/> Kidney disease
<input type="checkbox"/> <input type="checkbox"/> Lung disease (asthma, bronchitis, emphysema, pneumonia, TB, etc.)	<input type="checkbox"/> <input type="checkbox"/> Blood or bleeding disorders (i.e., anemia, sickle cell, etc.)	<input type="checkbox"/> <input type="checkbox"/> Infectious disease (HIV, TB, hepatitis, etc.)
<input type="checkbox"/> <input type="checkbox"/> Coronary artery disease / heart attack; when? _____	<input type="checkbox"/> <input type="checkbox"/> Liver disease (hepatitis, jaundice, cirrhosis, etc.)	<input type="checkbox"/> <input type="checkbox"/> Blood clots, pulmonary embolus
<input type="checkbox"/> <input type="checkbox"/> Heart rhythm abnormality	<input type="checkbox"/> <input type="checkbox"/> Ulcer disease	<input type="checkbox"/> <input type="checkbox"/> Thyroid disease
<input type="checkbox"/> <input type="checkbox"/> Heart valve disease	<input type="checkbox"/> <input type="checkbox"/> Congestive heart failure	<input type="checkbox"/> <input type="checkbox"/> Other (please specify)

**REVIEW OF SYSTEMS (Check "Yes" for all that you have experienced recently)**

Yes No	Yes No
<input type="checkbox"/> <input type="checkbox"/> neurologic problems-speech, weakness, dizziness	<input type="checkbox"/> <input type="checkbox"/> skipped heart beats / palpitations
<input type="checkbox"/> <input type="checkbox"/> frequent headaches	<input type="checkbox"/> <input type="checkbox"/> breathing problems, cough, shortness of breath
<input type="checkbox"/> <input type="checkbox"/> nausea / vomiting	<input type="checkbox"/> <input type="checkbox"/> bowel problems, blood in stools
<input type="checkbox"/> <input type="checkbox"/> weight loss	<input type="checkbox"/> <input type="checkbox"/> urinary problems, infections
<input type="checkbox"/> <input type="checkbox"/> fever / chills/ night sweats	<input type="checkbox"/> <input type="checkbox"/> skin problems
<input type="checkbox"/> <input type="checkbox"/> visual problems	<input type="checkbox"/> <input type="checkbox"/> easy bruising or bleeding problems
<input type="checkbox"/> <input type="checkbox"/> ear, nose, mouth, throat problems	<input type="checkbox"/> <input type="checkbox"/> bone or joint problems, arthritis
<input type="checkbox"/> <input type="checkbox"/> chest pain / angina	<input type="checkbox"/> <input type="checkbox"/> are you currently pregnant?

**SOCIAL HISTORY:**

Smoking: Yes \_\_\_ No \_\_\_ Amount \_\_\_ pack/day Previous smoker? Yes \_\_\_ No \_\_\_  
 Alcohol: Yes \_\_\_ No \_\_\_ Amount \_\_\_ drinks/week Marital Status: Single Married Divorced Widowed

**FAMILY HISTORY: (Check all medical problems that family members have or had)**

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Stroke	<input type="checkbox"/> Bleeding tendency
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Nervous system (epilepsy, etc.)	<input type="checkbox"/> Lung disease
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Muscle disease
<input type="checkbox"/> Cancer (Type _____)	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Anesthetic complications

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_ Reviewed by \_\_\_\_\_

