UNM Orthopaedics Health History Form

This form will become part of your medical record. Please fill out as accurately as possible.

Patient Name:_______________________________ **Date of Birth:**____________ **Age:**______ Are you **RIGHT** or **LEFT** handed?

Name of REFERRING medical provider:_______________________________________ (MD, DO, PA, RNP, chiropractor)

Do you have, or have you ever had, any of the following **MEDICAL PROBLEMS:**	Circle your answer:	List details to these or any **OTHER** Medical Problems you have or have had:
Heart attack	YES NO	
High blood pressure	YES NO	
High cholesterol	YES NO	
Diabetes	YES NO	
Stroke	YES NO	
Asthma	YES NO	
Emphysema/COPD	YES NO	
Ulcers/Reflux	YES NO	
Rheumatoid arthritis	YES NO	
Gout	YES NO	
Seizures/Epilepsy	YES NO	
Thyroid disease	YES NO	
Hepatitis	YES NO	
HIV/AIDS	YES NO	
Cancer	YES NO	

List any **DRUG ALLERGIES:**

Circle any of the following if you are ALLERGIC:

Iodine IV Contrast Shellfish Latex

List any **MEDICATIONS** you are taking:

SOCIAL HISTORY:

Are you employed? YES NO

Occupation________________________________ Date last worked:____________

Do or did you ever smoke? YES NO ____Packs per day for______ years

Did you quit? YES NO If so, when did you quit?_________________

Other tobacco/nicotine products? YES NO What kind? _______________

Drink alcohol? YES NO How much and how often?_________________

History of illegal drugs/substance abuse? YES NO

What kind?________________________________

Are you: Single Married Divorced Separated Widowed

Do you live alone? YES NO

Do you Exercise? Never Rarely Weekly Daily

What type?_________________________________

List any **SURGERIES** you have had and, if known, the **YEAR** and the name of the Surgeon:

FAMILY HISTORY

Do any of your grandparents, parents or siblings have any of the following:

Condition	Answer
Diabetes	YES NO
High blood pressure	YES NO
Heart attack	YES NO
Stroke	YES NO
Rheumatoid arthritis	YES NO
Bleeding disorders	YES NO
Cancer	YES NO

REVIEW OF SYSTEMS: Do you have NOW, or have you had RECENTLY, problems with any of the following:	Circle your answer:
Fevers, chills, weight loss	YES NO
Eyes	YES NO
Ears, Nose, Throat	YES NO
Teeth, Mouth	YES NO
Chest pain, Heart Problems	YES NO
Shortness of Breath, Lungs	YES NO
Constipation, Diarrhea	YES NO
Urinary tract infection	YES NO
Joint pain, Joint stiffness	YES NO
Skin rashes, lesions	YES NO
Migraines, Headaches	YES NO
Blackouts/Falling	YES NO
Balance problems	YES NO
Psychological problems/Depression	YES NO
High cholesterol	YES NO
Diabetes	YES NO
Bleeding disorders	YES NO
Blood clots, DVT	YES NO
Seasonal allergies	YES NO

Patient Label

Patient Signature: _________________________________ **Date:** __________

MD Signature: ____________________________________ **Date:** __________