WHS Orthopedic & Sports **PATIENT INFORMATION FORM**

Name: ____ DOB:____________________________________

Reason for today's visit: ____

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Current List of Medications

List all medication you are currently taking. Please include non-prescription medications, such as aspirin, Tylenol, Vitamins and herbal supplements.

Name	Dosage/Strength	Reason

Past medical History

Check all that apply

☐ Alcohol Abuse	☐ Diabetes	☐ Lumbar Stenosis
☐ Allergic Rhinitis	☐ Diabetes (Insulin Depend)	☐ Osteoarthritis
☐ Alzheimers	☐ Drug Abuse	☐ Osteopenia
☐ Anemia	☐ Emphysema	☐ Osteoporosis
☐ Anxiety	☐ GERD (Heartburn)	☐ Palpitations
☐ Asthma	☐ Gout	☐ Peptic Ulcer Disease
☐ Atrial Fibrillation	☐ Hepatitis	☐ PVD (Vascular Disease)
☐ BPH (Enlarged Prostate)	☐ HIV/AIDS	☐ Rheumatoid Arthritis
☐ Bronchitis-Chronic	☐ Hepatitis	☐ RLS(Restless Leg Syndrome)
☐ Cancer	☐ Hyperlipidemia (High Chol)	☐ Sexually Transmitted Disease
☐ Cardiomyopathy	☐ Hypertension (High Blood Pressure)	☐ Sleep Apnea
☐ Colon Polyps	☐ Hyperthyroidism	☐ Tuberculosis
☐ COPD (Lung Disease)	☐ Hypothryoidism	☐ Other (Please specify)
☐ CVA (Stroke)	☐ Irritable Bowel Disease	
☐ Dementia	☐ Kidney Disease	
☐ Depression	☐ Low Back Pain	

Surgery History

Check all that apply and year (if known)

☐ Amputation	Year:	☐ Hip Replacement	Year:
☐ Appendectomy	Year:	☐ Hysterectomy	Year:
☐ Arthroscopy	Year:	☐ Knee Replacement	Year:
☐ Breast Lumpectomy	Year:	☐ Lap Band	Year:
☐ Bypass in Leg	Year:	☐ Ovary Removal	Year:
☐ Cardiac Bypass	Year:	☐ Pacemaker	Year:
☐ Cardiac Cath	Year:	☐ Prostate Surgery	Year:
☐ Cataracts	Year:	☐ Stent-Heart	Year:
☐ Colon Resection	Year:	☐ Stent-Kidney	Year:
☐ Colonoscopy	Year:	☐ Stent-Leg	Year:
☐ Cystoscopy	Year:	☐ Tonsils	Year:
☐ Endoscopy	Year:	☐ Tubes in Ears	Year:
☐ Gall Bladder Removal	Year:	☐ Vasectomy	Year:
☐ Gastric Bypass	Year:	☐ Other (Please specify)	Year:
☐ Hernia Repair	Year:	☐	

Family Medical History

Has any family member/relative had the following?

Illness/Type	Family Member/Relative
☐ Cancer: Breast	
☐ Cancer: Colorectal	
☐ Cancer: Ovarian	
☐ Cancer: Prostate	
☐ Cancer: Other	
☐ High Blood Pressure	
☐ Heart Disease	
☐ Diabetes	
☐ Stroke	
☐ Depression	
☐ Anxiety	
☐ Glaucoma	
☐ Alcohol Abuse	
☐ Drug Abuse	
☐ Thyroid Disease	
☐ Rheumatoid Arthritis	
☐ Other	
☐ Other	

Allergies

List all known allergies + reason

Allergy	Reaction

Social History

Tobacco Use: Smoker Smokeless Non-Smoker

Have you ever used tobacco products? ( ) No ( ) Yes

What kind: _________________ How much: _________________ How many years: __________

Former Smoker-How long ago did you quit? ___________________________________

Other tobacco use (Chew, Snuff, Pipe)? ___________________________________

Alcohol and Drug Use: ( ) None

Did you have a drink containing alcohol in the past year? ( ) Yes ( ) No

How often did you have an alcoholic drink? *Never Monthly or less 2-4/mo 2-3/wk 4 or more/wk*

What kind: _________________ How much: _________________ How many years: __________

Do you use drugs for reason that are not medical? ( ) No ( ) Yes If yes, please list_________________