ORTHOPEDIC SURGERY ASSOCIATES

COMPREHENSIVE HISTORY FORM

DATE:_____

Name: _____D.O.B.____/_____/____AGE: _____

Describe your main problem:_____

_____

Where is your problem located?_____

How severe is your problem?_____

How long have you had this problem?_____

When does problem occur?_____

Other symptoms associated with this problem?_____

_____

List Medications/Supplements you are currently taking: **Dosage:**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Do you have a personal care Physician? ***(if yes please list***) NO YES

Name: _____

Address:_____Phone:_____

Was your appointment with OSA requested by a Physician? NO YES

(If yes and not the same as above please list) Same as above

Name: _____

Address:_____Phone:_____

Any known drug/food **ALLERGIES?** NO YES

(if yes please list)

_____

_____

_____

_____

List previous hospitalizations/surgeries/ serious injuries, when and age.

List	Date / Age
_____	_____/_____
_____	_____/_____
_____	_____/_____
_____	_____/_____
_____	_____/_____
_____	_____/_____
_____	_____/_____
_____	_____/_____
_____	_____/_____

Have you seen anyone else for this problem? NO YES

(if yes please list)

Name:_____

Address:_____

City/State:_____

Phone:_____

Have you and/or your family ever had the following?

	You	Mother	Father	Brother(s)	Sister(s)	Other	
Diabetes	ĺ	ĺ	ĺ	ĺ	ĺ	ĺ	_____
Heart Trouble	ĺ	ĺ	ĺ	ĺ	ĺ	ĺ	_____
Blood clots	ĺ	ĺ	ĺ	ĺ	ĺ	ĺ	_____
High B/P	ĺ	ĺ	ĺ	ĺ	ĺ	ĺ	_____
Cancer	ĺ	ĺ	ĺ	ĺ	ĺ	ĺ	_____
Stroke	ĺ	ĺ	ĺ	ĺ	ĺ	ĺ	_____
Arthritis/gout	ĺ	ĺ	ĺ	ĺ	ĺ	ĺ	_____
Lung Problems	ĺ	ĺ	ĺ	ĺ	ĺ	ĺ	_____
Vascular disease	ĺ	ĺ	ĺ	ĺ	ĺ	ĺ	_____
Anesthesia Problems	ĺ	ĺ	ĺ	ĺ	ĺ	ĺ	_____

Patient Social History: Who lives with you? Spouse I live alone Other_____

What is your current occupation?_____or Retired_____

Marital status: Single Married Separated Divorced Widowed Other _____

Do you drink alcohol? Never Rarely Moderate Daily _____

Tobacco use? NO / YES How many years?_____Packs per day?_____When quit?_____

Have you ever used street drugs? NO /YES If yes, Specify_____

Do you exercise? NO / YES How often?_____Describe_____

Have you had any problems of falling in the past year? NO / YES Describe_____

_____

CONTINUED ON OTHER SIDE

Are you <u>currently experiencing any of the following</u> ?

Pleas answer <u>ALL</u> questions!

<u>CONSTITUTIONAL</u>

Recent weight change……	NO	YES
Fever ……	NO	YES
Chills ……	NO	YES
Fatigue ……	NO	YES

<u>EYES</u>

Eyes disease/injury ……	NO	YES
Wear glasses/contact lens……	NO	YES
Blurred/double vision……	NO	YES

<u>MOUTH AND THROAT</u>

Dental work needed……	NO	YES
Gum disease/infection……..	NO	YES

<u>CARDIOVASCULAR</u>

Heart trouble……..	NO	YES
Chest pain……	NO	YES
Sudden heart beat changes……	NO	YES
Swelling of feet, ankles/hands…	NO	YES
Heart attack……..	NO	YES
High blood pressure……..	NO	YES

<u>RESPIRATORY</u>

Frequent coughing……	NO	YES
Shortness of breath……..	NO	YES
Asthma/wheezing……	NO	YES
Emphysema……..	NO	YES
Pneumonia……	NO	YES
Tuberculosis……..	NO	YES

<u>GASTROINTESTINAL</u>

Liver disease……..	NO	YES
Hepatitis……	NO	YES
Jaundice……	NO	YES

<u>URINARY</u>

Urinary tract infections……	NO	YES
Bladder infections……	NO	YES
Kidney stones……..	NO	YES
Kidney disease or failure…….	NO	YES

<u>MUSCULOSKELETAL</u>

Joint Pain ……	NO	YES
Joint Stiffness/Swelling……	NO	YES
Weakness of muscles/joints…..	NO	YES
Muscle pain or cramps……	NO	YES
Back Pain ……	NO	YES
Difficulty in walking……..	NO	YES
Fibromyalgia ……	NO	YES
Rheumatoid arthritis ……	NO	YES

<u>SKIN</u>

Rash or itching……..	NO	YES
Change in skin color……	NO	YES
Change in hair/nails……..	NO	YES
Varicose veins……..	NO	YES
Skin Ulcers……	NO	YES

<u>NEUROLOGICAL</u>

Frequent/recurring headaches…	NO	YES
Light headed or dizzy……..	NO	YES
Convulsions/seizures……	NO	YES
Numbness/tingling sensations…	NO	YES
Tremors……..	NO	YES
Paralysis……	NO	YES
Stroke……	NO	YES
Head Injury……	NO	YES
Polio……	NO	YES

<u>PSYCHIATRIC</u>

Memory loss or confusion……..	NO	YES
Nervousness……	NO	YES
Depression……	NO	YES
Sleep problems……	NO	YES
Anxiety……	NO	YES

<u>ENDOCRINE</u>

Thyroid disease……	NO	YES
Diabetes……	NO	YES
Date of onset? ……	_____	
Diet controlled?.....	NO	YES
Insulin dependent?.....	NO	YES
Excessive thirst or urination……	NO	YES
Heat or cold intolerance……..	NO	YES

<u>HEMATOLOGIC/LYMPHATIC</u>

Slow to heal after cuts……	NO	YES
Easily bruise or bleed……..	NO	YES
Anemia……..	NO	YES
Phlebitis……	NO	YES
Past transfusion……	NO	YES
Enlarged glands……	NO	YES

Patient Signature:_____ **Date:**_____

Physician Signature:_____ **Date:**_____