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________________