



# Interlakes Orthopaedic Surgery

Chart # \_\_\_\_\_

This important information is confidential. No one other than your healthcare provider will have access or knowledge of this information without your consent. Thank you very much for taking the time to fill out this form. Completion of this history allows us to provide you the most complete medical care possible. This form will be reviewed with you during your visit. Thank You

**Name:** \_\_\_\_\_ **Birthdate:** \_\_\_\_\_ **Age:** \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

What brings you to see the doctor today? **(Please be specific.)**

**Date of injury (if injury):** \_\_\_\_\_ **Body part involved:** \_\_\_\_\_

**Hospital / Surgical History:**  None

<u>Illness or Operation</u>	<u>Date</u>	<u>Illness or Operation</u>	<u>Date</u>
1)		6)	
2)		7)	
3)		8)	
4)		9)	
5)		10)	

**Do you have any of the following:**

- Artificial Joint                       Other Prosthesis/Implant                       Pacemaker  
 Artificial Limb                      If yes, what \_\_\_\_\_                       Defibrillator

**Allergies:**  None                      Are you allergic to **LATEX**?    YES     NO

Please list any medications, dyes, food, contact or environmental substances to which you have had an allergic or bad reaction.

**Medications:**  None

Please list any prescription medications, over the counter medications, vitamins, herbs or nutritional supplements that you are now taking. Please include the dosage amount and the times a day you take them.

1)	5)	9)
2)	6)	10)
3)	7)	11)
4)	8)	12)

**Past Medical History: (check those that apply to you)**

- |  |                                       |  |   |   |
|--|---------------------------------------|--|---|---|
| <input type="checkbox"/> Pneumonia           | <input type="checkbox"/> Bronchitis   | <input type="checkbox"/> Anemia                | <input type="checkbox"/> Ulcers             | <input type="checkbox"/> GERD/Hiatal hernia     |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Emphysema    | <input type="checkbox"/> Hepatitis/Jaundice    | <input type="checkbox"/> Depression         | <input type="checkbox"/> Hypothyroid            |
| <input type="checkbox"/> Stroke              | <input type="checkbox"/> Seizures     | <input type="checkbox"/> Phlebitis/Blood Clots | <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Sickle Cell disease    |
| <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Thyroid Disorder      | <input type="checkbox"/> Cancer             | <input type="checkbox"/> High Cholesterol       |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Arthritis             | <input type="checkbox"/> Angina             | <input type="checkbox"/> Enviromental allergies |
| <input type="checkbox"/> Tuberculosis        | <input type="checkbox"/> Diabetes     | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Heart Murmur       |   |

**Women Only:** Last Pap Smear: \_\_\_\_\_ Last Mammogram: \_\_\_\_\_ Last Bone density: \_\_\_\_\_

**Family History** Is there a history of any of the following in your family? **(Check those that apply)**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Kidney Disease    | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Arthritis         | <input type="checkbox"/> Sickle Cell disease |
| <input type="checkbox"/> Cancer        | <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/>                     |

**Social History:**

Occupation: \_\_\_\_\_ Date last worked: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Do you exercise regularly?  YES  NO    What type? \_\_\_\_\_    How often? \_\_\_\_\_

Have you ever smoked?  YES  NO    I currently smoke \_\_\_\_\_ packs per day.    I have smoked for \_\_\_\_\_ years.

I formerly smoked but stopped in: \_\_\_\_\_ (list year)    \_\_\_\_\_

Do you use other forms of tobacco?  YES  NO    Do you use illicit drugs?  YES  NO    Do you drink alcohol?  YES  NO

How often/how much? \_\_\_\_\_    How often/how much? \_\_\_\_\_    How often/how much? \_\_\_\_\_

Have you ever been exposed to anyone with tuberculosis?  YES  NO

Are you currently experiencing unusual stress?  YES  NO    Explain: \_\_\_\_\_

### Recent diagnostic testing

(Please include any tests performed within the past year, ie: lab tests, x-rays, cardiac tests, **colonoscopy**, etc.)

<u>Test</u>	<u>Date</u>	<u>Where</u>	<u>Test</u>	<u>Date</u>	<u>Where</u>

### Please check all conditions you have now or in the past:

<b>Gastrointestinal</b> <input type="checkbox"/> None <input type="checkbox"/> Poor appetite <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Pain in swallowing <input type="checkbox"/> Heartburn <input type="checkbox"/> Indigestion Ulcer <input type="checkbox"/> Stomach <input type="checkbox"/> Duodenum <input type="checkbox"/> Internal bleeding <input type="checkbox"/> Belly pain <hr/> <input type="checkbox"/> Gall bladder problems <input type="checkbox"/> Liver problems <input type="checkbox"/> Jaundice <input type="checkbox"/> Hepatitis <b>Bowels</b> <input type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Constipation	<b>General</b> <input type="checkbox"/> None <input type="checkbox"/> Weight loss <input type="checkbox"/> Weight gain  <b>Genitourinary</b> <input type="checkbox"/> None <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Urinating frequently <input type="checkbox"/> Burning/pain with urination  <b>Respiratory</b> <input type="checkbox"/> None <input type="checkbox"/> Wheezing <input type="checkbox"/> Prolonged cough <input type="checkbox"/> Coughing up blood <input type="checkbox"/> Emphysema Shortness of breath <input type="checkbox"/> Waking up <input type="checkbox"/> Lying down <input type="checkbox"/> Other -  <b>Eyes</b> <input type="checkbox"/> None <input type="checkbox"/> Glaucoma <input type="checkbox"/> Double vision <input type="checkbox"/> Blurred vision <input type="checkbox"/> Glasses/contacts	<b>Skin</b> <input type="checkbox"/> None <input type="checkbox"/> Excessive sweating <input type="checkbox"/> Oily skin <input type="checkbox"/> Dry skin  <b>Neuro &amp; Psyc</b> <input type="checkbox"/> None <input type="checkbox"/> Anxiety <input type="checkbox"/> Headaches <input type="checkbox"/> Depression <input type="checkbox"/> Seizures <input type="checkbox"/> Memory Loss <input type="checkbox"/> Head injuries <input type="checkbox"/> Blackouts <input type="checkbox"/> Change in sensation <input type="checkbox"/> Localized weakness <input type="checkbox"/> <b>Claustrophobia</b>  <b>Endocrine</b> <input type="checkbox"/> None <input type="checkbox"/> Changes in skin texture <input type="checkbox"/> Cold intolerance <input type="checkbox"/> Heat intolerance <input type="checkbox"/> History of diabetes <input type="checkbox"/> Excessive thirst	<b>Ears/Nose/Throat</b> <input type="checkbox"/> None <input type="checkbox"/> Hoarseness <input type="checkbox"/> Ringing in your ears <input type="checkbox"/> Hay fever <input type="checkbox"/> Sinus infections <input type="checkbox"/> Goiter <input type="checkbox"/> Ear Infections <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Frequent nosebleeds  <b>Cardiovascular</b> <input type="checkbox"/> None <input type="checkbox"/> Angina/chest pain <input type="checkbox"/> High/low blood pressure <input type="checkbox"/> Ankle swelling <input type="checkbox"/> Murmurs <input type="checkbox"/> Irregular heart rate <input type="checkbox"/> Heart palpitations <input type="checkbox"/> Leg cramps <input type="checkbox"/> Leg pain with walking
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Height \_\_\_\_\_

Weight \_\_\_\_\_

**Patient Signature:**

**Nurse Review:**

History of Present Illness: (To be completed by physician.)

(Sign & date)

Physician Signature

Date