Health History

Name: _____ Today's Date: _____

Date: of Birth: _____ Sex: _____ Gender: _____

Social History

Occupation _____

Marital Status; M S W D (please circle)

Use of Tobacco Never Previous but quit Current # packs per day: _____

Use of Alcohol Never Rarely Moderate Daily Type & Frequency: _____

Use of Marijuana Never Previous but quit Current Medical or Recreational? _____

Street Drug Use Never Name of Drug: Last used: _____

Family History (list major family medical history)

Father: _____ Living/Deceased

Mother: _____ Living/Deceased

Siblings: _____ Living/Deceased

Other: _____ Living/Deceased

Not Known

Do you have or have you had any of the medical Problems listed Below (please circle yes or no)

Angina/Chest pain	*Y/N*	*Edema/Swelling*	*Y/N*	***MRSA*** *(Resistant bacterial infection)*	*Y/N*
Asthma	*Y/N*	*Emphysema*	*Y/N*	*Active / Non Active*	
Arthritis	*Y/N*	*Fibromyalgia*	*Y/N*	*Neurological Problems*	*Y/N*
Anemia	*Y/N*	*Gout*	*Y/N*	*Type:* _____	
Alcohol abuse	*Y/N*	*Glaucoma*	*Y/N*	*Osteoporosis*	*Y/N*
Bowel Problems	*Y/N*	*Heartburn*	*Y/N*	*Problems w/ Surgery*	*Y/N*
Type: _____		*Heart Attack*	*Y/N*	*Pulmonary Embolism*	*Y/N*
Bleeding disorders	*Y/N*	*Date:* _____		*Respiratory Issues*	*Y/N*
Type: _____		*High Blood Pressur*	*Y/N*	*Type:* _____	
Bladder Problems	*Y/N*	*High Cholesterol*	*Y/N*	*Seasonal Allergies*	*Y/N*
Type: _____		*Heart Valve Disord*	*Y/N*	*Skin Disorders*	*Y/N*
Blood Clots	*Y/N*	*Hepatitis*	*Y/N*	*Type:* _____	
Cancer	*Y/N*	*Type:* _____		*Seizure disorders*	*Y/N*
Type: _____		*Immune Disorder*	*Y/N*	*Sleep Apnea*	*Y/N*
Cataracts	*Y/N*	*Type:* _____		*Stroke*	*Y/N*
Diabetic	*Y/N*	*Kidney Problems*	*Y/N*	*Date:* _____	
Type: _____		*Liver Disease*	*Y/N*	*Thyroid*	*Y/N*
Depression	*Y/N*	*Lung Disease*	*Y/N*	*Weight Loss*	*Y/N*
Drug Abuse	*Y/N*	*Mental Illness*	*Y/N*	*Weight Gain*	*Y/N*
				Other: _____	

WASHINGTON ORTHOPAEDIC CENTER

Clinical Use Only

Patient ID # _____

PLEASE SEE BACKSIDE FOR ADDITIONAL INFORMATION

Allergy to Latex? Y/N **Allergy to Metal?** Y/N

Allergies: *(please list all other allergies)* NONE

Surgeries: *(please list all surgeries and the date)* NONE

Medication *(please list all medications and vitamins or provide a list)* NONE