HVMG Orthopedics

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HERITAGE VALLEY HEALTH SYSTEM

MEDICAL HISTORY

Patient Name:	Height:	Weight:
Family Physician:	Phone Number:	

Please list any medical conditions that you have. If none, please check none. ☐ None

Do you have Sleep Apnea? ☐ No ☐ Yes

Do you use CPAP/BIPAP? ☐ No ☐ Yes

If so, what are your settings for your machine?_____

Do you have Diabetes? ☐ No ☐ Yes

Do you have OR have you ever been treated for cancer? ☐ No ☐ Yes, type: _____

Do you take blood thinners (including aspirin)? ☐ No ☐ Yes, which one _____

Please list any surgeries or hospitalizations you have had in the past. If none, please check none. ☐ None

Please list all medications you are currently taking. (Include birth control pills, vitamins, supplements, etc.)
Please include strength (how many milligrams & how many times a day you take it). If none, please check none. ☐ None

Medication	Dose	Frequency	Medication	Dose	Frequency

Please list all medications to which you are allergic and type of reaction you had. If none, please check none. ☐ None

Are you allergic to latex? ☐ Yes ☐ No

Family History

My family members have a history of the following medical problems. Check yes or no.

Asthma	☐ Yes	☐ No	Cancer	☐ Yes	☐ No
Bleeding problems	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Blood vessel disease (circulation problems)	☐ Yes	☐ No	High blood pressure	☐ Yes	☐ No
			Seizures	☐ Yes	☐ No

PLEASE CONTINUE AND COMPLETE OPPOSITE SIDE OF PAGE.

Please circle the correct answer below:

Have you ever been tested for the Aids Virus (HIV)? Yes No — If yes, what were the results: Positive or Negative

Have you been diagnosed with Hepatitis? Yes No — If yes: A B C

Do you smoke? Yes No — If yes, how much per day?

Have you ever smoked? Yes No

Do you drink alcohol? Yes No — If yes, how much per day?

Do you use social drugs? Yes No — If yes, what and how often?

Have you ever been treated for alcoholism or drug abuse? If so, what? and when?

Are you pregnant or have any reason to think you might be? Yes No

Review of Systems

Do you have or have had any of the following? Check yes, no or ongoing.

Anxiety	☐ Yes	☐ No	☐ Ongoing
Arthritis	☐ Yes	☐ No	☐ Ongoing
Artificial Valve	☐ Yes	☐ No	☐ Ongoing
Bleeding Tendencies	☐ Yes	☐ No	☐ Ongoing
Blood Transfusions	☐ Yes	☐ No	☐ Ongoing
Bone Disease	☐ Yes	☐ No	☐ Ongoing
Chest Pain	☐ Yes	☐ No	☐ Ongoing
Constipation	☐ Yes	☐ No	☐ Ongoing
Depression	☐ Yes	☐ No	☐ Ongoing
Diarrhea	☐ Yes	☐ No	☐ Ongoing
Epilepsy	☐ Yes	☐ No	☐ Ongoing
Heart Attack in Past	☐ Yes	☐ No	☐ Ongoing
Heart Disease	☐ Yes	☐ No	☐ Ongoing
Heartburn	☐ Yes	☐ No	☐ Ongoing
Heartburn, Frequent	☐ Yes	☐ No	☐ Ongoing
High Blood Pressure	☐ Yes	☐ No	☐ Ongoing
Irregular Heartbeat	☐ Yes	☐ No	☐ Ongoing
Jaundice	☐ Yes	☐ No	☐ Ongoing
Kidney Disease	☐ Yes	☐ No	☐ Ongoing
Kidney Stones	☐ Yes	☐ No	☐ Ongoing
Liver Disease	☐ Yes	☐ No	☐ Ongoing
Lung Disease	☐ Yes	☐ No	☐ Ongoing

Nausea or Vomiting	☐ Yes	☐ No	☐ Ongoing
Pacemaker	☐ Yes	☐ No	☐ Ongoing
Defibrillator	☐ Yes	☐ No	
Past Stroke	☐ Yes	☐ No	☐ Ongoing
Prolonged Bleeding from Surgery	☐ Yes	☐ No	☐ Ongoing
Rectal Bleeding	☐ Yes	☐ No	☐ Ongoing
Rheumatic Heart Disease	☐ Yes	☐ No	☐ Ongoing
Seizures	☐ Yes	☐ No	☐ Ongoing
Severe Nosebleeds	☐ Yes	☐ No	☐ Ongoing
Shortness of Breath	☐ Yes	☐ No	☐ Ongoing
Stomach Pain	☐ Yes	☐ No	☐ Ongoing
Think I'm at High Risk for AIDS	☐ Yes	☐ No	☐ Ongoing
Ulcer Disease	☐ Yes	☐ No	☐ Ongoing
Ulcers in Past	☐ Yes	☐ No	☐ Ongoing
Urination, Frequent	☐ Yes	☐ No	☐ Ongoing
Urination, Painful	☐ Yes	☐ No	☐ Ongoing
Urination, Slow	☐ Yes	☐ No	☐ Ongoing
Veneral Disease	☐ Yes	☐ No	☐ Ongoing
Weight Loss	☐ Yes	☐ No	☐ Ongoing

I hereby state that the above information is true and correct to the best of my knowledge.

Signature _____ Date _____

Print Name _____