REDWOOD ORTHOPAEDIC SURGERY ASSOCIATES

Patient Health History

Patient Name _____ Date _____

Height _____ Weight _____ Date of Birth _____ Age _____ Sex: ☐ Male ☐ Female

☐ R ☐ L Handed

Do you have, or did you ever have? – Check Yes or No

Vision problems	☐ Yes	☐ No	Kidney or Bladder diseases	☐ Yes	☐ No
Hearing problems	☐ Yes	☐ No	Sexually transmitted diseases	☐ Yes	☐ No
Respiratory problems	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Tumor or Cancer	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No	Phlebitis	☐ Yes	☐ No
Nose bleeds	☐ Yes	☐ No	Poliomyelitis	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No	Scoliosis	☐ Yes	☐ No
Heart trouble	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No
Heart attack	☐ Yes	☐ No	Arthritis	☐ Yes	☐ No
Mitral valve prolapse	☐ Yes	☐ No	Gout	☐ Yes	☐ No
Abnormal bleeding	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Swelling in your ankles	☐ Yes	☐ No	Skin rashes or Dermatitis	☐ Yes	☐ No
Fainting or blacking out	☐ Yes	☐ No	Cuts or Scratches that heal slowly	☐ Yes	☐ No
Convulsions or Epilepsy	☐ Yes	☐ No	Severe Anemia	☐ Yes	☐ No
Do you smoke (If yes, how many _____)	☐ Yes	☐ No	Men: Prostate trouble	☐ Yes	☐ No
Do you drink more than 2 alcoholic drinks a day	☐ Yes	☐ No	Bloody urine	☐ Yes	☐ No
			Up at night to urinate	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	Women: Age period started		
Rheumatic fever	☐ Yes	☐ No	Have you gone through menopause	☐ Yes	☐ No
Stomach ulcers	☐ Yes	☐ No	If yes, at what age _____		
Hepatitis	☐ Yes	☐ No			

Smoking Status: ☐ Never Smoked ☐ Current Every Day Smoker ☐ Current Some Day Smoker ☐ Heavy Tobacco Smoker ☐ Light Tobacco Smoker ☐ Smoker, Current Status Unknown ☐ Unknown if Ever Smoked ☐ Former Smoker

List drug or food allergies ☐ None _____

List current medications you are taking ☐ None _____

Previous surgeries and dates _____

Have you had problems with anesthesia? ☐ Yes ☐ No If yes, please explain _____

Family History

Father ☐ Alive/ Health/ Illnesses _____ ☐ Deceased/ Cause of Death _____

Mother ☐ Alive/ Health/ Illnesses _____ ☐ Deceased/ Cause of Death _____

Siblings ☐ Alive/ Health/ Illnesses _____ ☐ Deceased/ Cause of Death _____

Please Sign The Following Form

To the best of my knowledge, the questions on this form have been answered accurately I understand that providing incorrect information can be hazardous to my health. It is my responsibility to inform the doctor of any changes in my medical status. I also authorize the health care staff of Redwood Orthopaedic Surgery Associates to perform the necessary services I may need.

Signature of Patient or Parent of Minor: _____ Date: _____

Reviewed by Physician: _____ Date: _____