**TEXAS HIP & KNEE SURGERY**



# PATIENT HEALTH HISTORY

DATE: ___________________________

**Please print, answer all questions and sign where indicated**

Patient's Name:_________________________________________Date of Birth:_______________________

Chief Complaint: ___________________________________________________________________________

Duration of symtoms/Date of onset: _____________________________________________________________

Please describe your injury or problem:

_____________________________________________________________________________________________

_____________________________________________________________________________________________

Was this an automobile accident? **Yes No** Were you injured on the job? **Yes No**

**MEDICATION HISTORY**

**ALLERGIES:** PLEASE CIRCLE ALL THAT APPLY

NO KNOWN DRUG ALLERGIES PENICILLIN CODEINE MORPHINE SULFA DEMEROL

BETADINE SOAP "MYCINS" KEFLEX ASPRIN SOMA FLEXERIL BEXTRA VIOXX

MOBIC IODINE-SHELLFISH

**Please list all medications you are currently taking (REMEMBER to include vitamins, herbs, minerals, & antibiotics)**

| Current Medications Dose Frequency | Current Medications Dose Frequency |
|---|---|
| **1.** _______________________________ | **11.** _______________________________ |
| **2.** _______________________________ | **12.** _______________________________ |
| **3.** _______________________________ | **13.** _______________________________ |
| **4.** _______________________________ | **14.** _______________________________ |
| **5.** _______________________________ | **15.** _______________________________ |
| **6.** _______________________________ | **16.** _______________________________ |

**TEXAS HIP & KNEE SURGERY**



**PAST MEDICAL HISTORY** (Please circle any current or past illnesses)

Congestive Heart Failure   Renal Dialysis   High Blood Pressure   Heart Attack   Osteoporosis

Gastric Ulcer   Gastric Reflux   Seizures   Blood Clots (DVT)   Rheumatoid Arthritis   Hepatitis   Glaucoma

Athma   Depression   Osteoathritis   Stroke   Gout   Lupus   HIV   Diabetes   Pulmonary Embolus

Bleeding disorder   Cancer (Specify type) ___________________________________________

**PAST SURGICAL HISTORY** (Please circle all that apply)

Heart   Kidney   Liver   Appendectomy   Tonsils   Hysterectomy   Prostate   Bladder suspension   Hernia

Cataracts   Gallbladder   Coronary Bypass (Number of Bypasses) _________   Back surgery   Neck surgery

Fracture Repair (specify site) ________________________________________________

Total Hip or Partial Hip Replacement: **Right**   **Left**   Total Knee Replacement: **Right**   **Left**

Other:

_____________________________________________________________________________________________

**FAMILY HISTORY**

Father: Age if living _____Deceased at age _____Mother: Age if living _____Deceased at age ______

Number of Sisters: __________ Number of Brothers__________ Number of Children __________

**Is there a family history of:** (Please circle **Yes** or **No**)

Diabetes **Yes No**   High Blood Pressure **Yes No**   Sudden Unexplained Death **Yes No**   Asthma **Yes No**

Epilepsy **Yes No**   Heart Attack **Yes No**   Arthritis **Yes No** Cancer **Yes No**   Other: ____________________

**SOCIAL HISTORY** (Please circle or fill in blanks)

SINGLE   MARRIED   WIDOWED   DIVORCED

Occupation: ____________________________________Highest level of Education completed: __________

Alcohol: Number of drinks per day ___________ ( ) I never drink alcohol

Smoking: Number of Packs per day _____________ for _________ years ( ) I never smoked

Quit smoking on or about ________________ Smoked # packs/day_________ for _________ years

# TEXAS HIP & KNEE SURGERY

**REVIEW OF SYSTEMS: (Please mark all that have occurred in the past year)**

**CONSTITUTIONAL / EYE & VISION / EARS & HEARING / NOSE & THROAT**

Fever Change in vision Loss of hearing Hoarseness / dry throat Chills Eye pain/redness Ear drainage

Difficulty Swallowing Night sweats Double vision Ringing noises Nosebleeds Frequent Fatigue Glasses

Contacts Ear Pain Ringing in Ears Unexpected Weight loss Freq. Eye watering Hearing aids

Change in smell/taste Weight gain Color blindness Dizziness Frequent infections Dry eyes Dentutres

Frequent itching

**CARDIOVASCULAR / RESPIRATORY / GASTROINTESTINAL / GENITOURINARY**

Chest pain Shortness of breath Bowel incontinence Bladder incontinence Ankle swelling Coughing up blood

Constipation Blood in urine Heart palpitations Wheezing Diarrhea Difficulty urinating Varicose veins

Pain with breathing Loss of Appetite Frequent urination Burning with urination Irregular Heart Beat

Hemorrhoids Freq. nighttime urination Heart murmur Black tarry stools Freq. urinary infections

**MUSCULOSKELETAL / NEUROLOGIC / PSYCHIATRIC / SKIN & BREAST**

Joint pain & stiffness Memory loss Depression Rash Seizures Difficulty sleeping Tattoos

Muscle weakness Tremors Skin ulcers/open wounds Loss of muscle mass Headaches Bipolar syndrome

Hair/Nail Changes Muscle spasms/cramping Paralysis Breast masses/tenderness Limited range of motion

Balance problems Keloid scar tendency

**ENDOCRINE HEMATOLOGIC / LYMPHATIC ALLERGIC / IMMUNOLOGIC**

Temp. intolerance Bruise Easily Receiving allergy shots Excessive thirst Abnormal Bleeding Allergies

Hot Flashes Axilla/groin tenderness Problems with immunizations Low sex drive Tender nodes/lumps

Prolonged healing tendency Sexual dysfunction Transfusions Lactose intolerance or other foods

____________________________________ **Reviwed By:**_____________________________

**PATIENT'S SIGNATURE DATE**