Orthopedic Institute of Central Florida

HEALTH HISTORY

Name: _____ Date ____/____/_____

HISTORY OF PRESENT ILLNESS

Chief Complaint (Why are you here?): _____

_____

MEDICATIONS: What medications are you currently taking?

_____

_____

_____

ALLERGIES: Are you allergic to (please check all that apply):

☐ None ☐ Penicillin ☐ Sulfa ☐ Demerol ☐ Aspirin ☐ Codeine ☐ Morphine

☐ Other: _____

PAST MEDICAL HISTORY:

☐ High Blood Pressure ☐ Heart Attack ☐ Diabetes ☐ Kidney Failure

☐ Hepatitis ☐ Cancer(Type) ☐ High Cholesterol ☐ Stroke

☐ Thyroid ☐ Other: _____

Are you or might you be pregnant? ☐ Yes ☐ No

PAST SURGICAL HISTORY:

☐ Heart Bypass ☐ Appendix ☐ Gallbladder ☐ Hysterectomy

☐ Neck/Back Surgery (Type) _____ ☐ Joint Replacement (Type) _____

☐ Other: _____

SOCIAL HISTORY:

Marital Status: ☐ Married ☐ Single ☐ Widowed

Work Occupation: _____ Employer Name: _____

Habits: Do you smoke cigarettes: ☐ Yes ☐ No Pack(s) per day: _____

Alcoholic beverages? ☐ Never ☐ Daily ☐ Social

REVIEW OF SYSTEMS (Last six months) Please read carefully and check where appropriate:

1.	**General**	☐
	Recent weight change (up or down)	☐
	Chills	☐
	Fever	☐
2.	**HEENT**	☐
	Headache	☐
	Change in Vision	☐
	Ear Pain	☐
	Nose Bleed	☐
	Hoarseness	☐
3.	**Respiratory**	☐
	Shortness of breath	☐
	Wheezing	☐
	Asthma	☐
	Pneumonia	☐
4.	**Cardiovascular**	☐
	Shortness of breath with exercise	☐
	Shortness of breath on lying down	☐
	Chest Pain	☐
	Heart Palpitations	☐
5.	**Gastro Intestinal**	☐
	Vomiting blood	☐
	Heartburn	☐
	Blood in stool	☐
	Ulcer	☐

Height	
Weight	
Pulse	

6.	**Urinary**	☐
	Kidney infection	☐
	Kidney stones	☐
7.	**Skin**	☐
	Rash	☐
	Skin Cancer	☐
	Hives	☐
	Psoriasis	☐
8.	**Neurological**	☐
	Headaches	☐
	Seizures	☐
	Stroke	☐
	Head trauma	☐
9.	**Psychiatric**	☐
	Depression	☐
	Anxiety	☐
	Psychiatric problem or hospitalization	☐
10.	**Musculoskeletal**	☐
	Arthritis	☐
	Joint Pain	☐
	Joint Stiffness	☐
	Joint Swelling	☐
	Rheumatism	☐
	Broken bone	☐
11.	**Hematology**	☐
	Anemia	☐
	Bleeding problems	☐