Bone & Joint Center
A Holland Hospital Physician Office

Patient Health History

(Please use blue or black ink only)

Name: _____Date:_____DOB:_____

Sex: **M** **F** Height: _____ Weight: _____ Handedness: R **L**

Primary Care Physician: _____ Referring Physician: _____

What problem brought you to our office today?

_____

_____

How long have you had this problem? (Specify date of injury)

_____

How often does it occur?

_____

Is your problem related to work or an auto accident? If so, when? _____

_____

Can you describe your symptoms?(aching, sharp, stabbing,etc)

_____

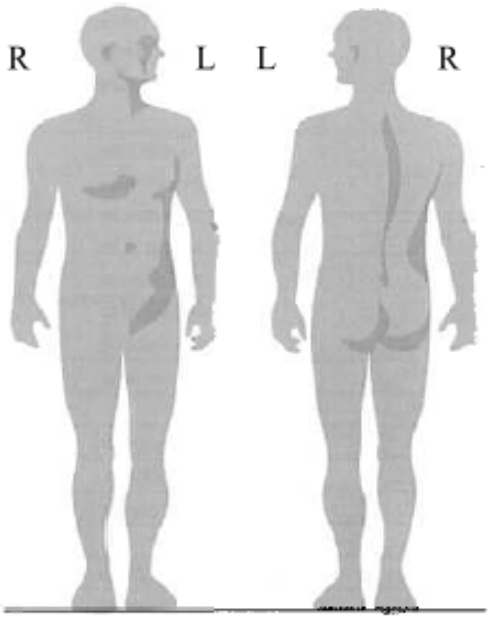
_____

What makes your symptoms worse?

_____

What makes your symptoms better?

_____



***Circle* the area above that is painful**

***Shade* areas of numbness or tingling**

Circle the number that best describes your ***current pain level***.

no pain 0 1 2 3 4 5 6 7 8 9 10 **worst pain** N/A

What treatments have you already attempted?

	Effective	Somewhat	Not Effective	Worse	Date
Physical Therapy					
Medications					
Heat/Ice					
Injection					
Brace					
Assistive Devices (walker, cane, crutches…)					
Activity Modification					

Diagnostic Studies: What tests have been completed? (List dates)

MRI_____ CT Scan_____ X-rays_____ EMG_____

Office Use Only:	Weight: _____	Height: _____	Blood Pressure: _____	BMI _____

Past Medical History: Please mark any medical problem that you **have now** or **have had in the past.**

□ High blood pressure	□Diabetes	□ Emphysema/COPD	□ Asthma	□ TB
□ Stroke/TIA	□ Heart Disease	□ Angina	□ Rheumatoid	□ Fibromyalgia
□ High Cholesterol	□Aneurysm	□ Stomach Ulcer	□ Hepatitis	□ Acid Reflux
□ Thyroid disease	□Osteoporosis	□ Seizure disorder	□ Kidney Disease	
□ Currently pregnant	□Depression	□ Bleeding disorder	□ Reaction to Anesthesia	

□ Other psychiatric illness (type):_____

□ Cancer (type):_____

□ Other medical illness (describe :) _____

Medication Allergies: List any medication allergy you have experienced. □ **No Allergies**

Name	Reaction	Name	Reaction
_____	_____	_____	_____
_____	_____	_____	_____

Metal Sensitivities/Allergies (nickel, silver, titanium, jewelry): NO YES_____

MRSA: NO YES

Medications: List the medications and dose that you take.

Name	Dosage	How Often	Name	Dosage	How Often
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Family History: Please mark any medical problems that exist in your family.

	Diabetes	High Blood Pressure	Heart Disease	Stroke	Mental Illness	Cancer	Bleeding Disorder	Emphysema / COPD	Other
Father									
Mother									
Siblings									
Daughter(s)									
Son(s)									
Paternal Grandfather									
Paternal Grandmother									
Maternal Grandfather									
Maternal Grandmother									

Aunt									
Uncle									

Social History:

What is your current marital status? □ Single □Married □ Divorced □Widowed

What is your current occupation? _____

What is your current work status? □ Fulltime □ Part Time □ Limited Duty□ Unable to Work □Without Employment

The last date I worked was: _____ I have been on disability since: _____

Current Nicotine user? □ **YES** □ **NO**

If **YES**, what? □ Cigarettes □ Pipe □ Cigars □ e-Cigs /Vaping □ Chewing Tobacco □ Marijuana How many years? _____

Former Nicotine user? □ Yes □ No How many years? _____ Quit date _____

Do you consume alcohol? **YES** **NO** How much? _____ How often? _____

Have you ever had a problem with alcohol in the past? **YES** **NO** When? _____

Have you ever used illegal drugs? **YES** **NO** When? _____

Have you ever had an addiction problem with narcotic pain medications? **YES** **NO** When? _____

Past Surgical History: Please list any **surgery** you have had in the past with the approximate date.

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Your Pharmacy: _____

Review of Systems for the last six months: Check (✔) "**yes**" or "**no**" for each sign/symptom.

	Yes	No
Constitutional:		
Weight Gain		
Weight Loss		
Fever		
Chills		
Sexual Dysfunction		
Eyes:		
Blurred Vision		
Double Vision		
Loss of Vision		
Head/Ears/Nose/Throat		
Headache		
Nasal Drainage		
Hearing Loss		
Cardiovascular/Respiratory:		
Chest Pain (angina)		
Palpitations		

	Yes	No
Heart Arrhythmia		
Shortness of Breath		
Gastrointestinal:		
Abdominal Pain		
Diarrhea		
Constipation		
Bowel Incontinence		
Blood in Stool		
Urinary:		
Difficulty Urinating		
Urinary Incontinence		
Urgency		
Neurological:		
Seizure		
Memory Loss		
Confusion		
Psychiatric:		
Depression		

	Yes	No
Mania		
Other		
Musculoskeletal:		
Leg Cramps		
Swelling		
Painful Joints		
Muscle Loss		
Bruising		
Skin:		
Cancer		
Rash		
Ulcer		
Allergy:		
Seasonal		
Tape		
Food		
Other:		

For "yes" responses, which physician(s) is/are treating these conditions? _____

I hereby certify that the above information is correct to the best of my knowledge. I will not hold my physician(s) or any of their staff responsible for any errors or omissions I have made in completing this form.

Signature: _____ Date: _____