

Today's Date \_\_\_\_\_

**SOUTH HILLS ORTHOPAEDIC SURGERY ASSOCIATES, P.C.  
PATIENT HEALTH HISTORY FORM**

Name \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Male \_\_\_ Female \_\_\_ Marital Status \_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Occupation \_\_\_\_\_

Were you referred to us by another physician? \_\_\_ Physician Name \_\_\_\_\_

**Personal Medical History**

Have **you** had or do **you** have symptoms of:

- | Yes   | No    |                           |
|-------|-------|---------------------------|
| _____ | _____ | Diabetes                  |
| _____ | _____ | Cancer                    |
| _____ | _____ | Thyroid Disease           |
| _____ | _____ | Kidney Disease            |
| _____ | _____ | Liver Problems            |
| _____ | _____ | Arthritis                 |
| _____ | _____ | Blood Disorders           |
| _____ | _____ | Hypertension              |
| _____ | _____ | Stomach Ulcers            |
| _____ | _____ | Gastric Reflux            |
| _____ | _____ | Glaucoma                  |
| _____ | _____ | Heart Attack/Angina       |
| _____ | _____ | Allergies, please specify |
| _____ | _____ | _____                     |
| _____ | _____ | _____                     |
| _____ | _____ | Other, please specify     |
| _____ | _____ | _____                     |

**Family Medical History**

Do you have a **family history** of:

- | Yes   | No    | Relationship                        |
|-------|-------|-------------------------------------|
| _____ | _____ | Diabetes _____                      |
| _____ | _____ | Cancer _____                        |
| _____ | _____ | Thyroid Disease _____               |
| _____ | _____ | Kidney Disease _____                |
| _____ | _____ | Liver Problems _____                |
| _____ | _____ | Arthritis _____                     |
| _____ | _____ | Blood Disorders _____               |
| _____ | _____ | Heart Disease _____                 |
| _____ | _____ | Osteoporosis _____                  |
| _____ | _____ | Back Problems _____                 |
| _____ | _____ | Neurological Disease _____          |
| _____ | _____ | Other, please specify _____         |
| _____ | _____ | _____                               |
| _____ | _____ | Mother deceased? Age at death _____ |
| _____ | _____ | Cause of death _____                |
| _____ | _____ | Father deceased? Age at death _____ |
| _____ | _____ | Cause of death _____                |

**Personal Social History**

Tobacco use (type and amount): \_\_\_\_\_ per day Alcohol use: \_\_\_\_\_ per day

Hobbies (please specify): \_\_\_\_\_

Do you exercise regularly? (specify type): \_\_\_\_\_

**Previous Surgery (of any kind):**

- |          |          |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

**Medications:**

- |          |          |          |
|----------|----------|----------|
| 1. _____ | 4. _____ | 7. _____ |
| 2. _____ | 5. _____ | 8. _____ |
| 3. _____ | 6. _____ | 9. _____ |

**Please turn page over and complete other side**

Name \_\_\_\_\_

Today's Date \_\_\_\_\_

**Review of Systems**

Have **you** had or do **you** have symptoms of:

**Ears:** Yes No  
 Ringing \_\_\_\_\_  
 Dizziness \_\_\_\_\_  
 Hearing Loss \_\_\_\_\_  
 Meniere's disease \_\_\_\_\_  
 Other: \_\_\_\_\_

**Genito-urinary:** Yes No  
 Trouble starting/stopping urination \_\_\_\_\_  
 Sores in groin/crotch \_\_\_\_\_  
 Pain/burning during urination \_\_\_\_\_  
 Other: \_\_\_\_\_

**Nose, Mouth, Throat:** Yes No  
 Dryness \_\_\_\_\_  
 Allergies \_\_\_\_\_  
 Sores \_\_\_\_\_  
 Swallowing/Speech problems \_\_\_\_\_  
 Other: \_\_\_\_\_

**Skin:** Yes No  
 Rashes \_\_\_\_\_  
 Spots \_\_\_\_\_  
 Sores \_\_\_\_\_  
 Lumps \_\_\_\_\_  
 Other: \_\_\_\_\_

**Cardiovascular:** Yes No  
 Heart Disease \_\_\_\_\_  
 High Blood Pressure \_\_\_\_\_  
 Chest Pain/Tightness/Angina \_\_\_\_\_  
 MI/Heart Attack \_\_\_\_\_  
 Coolness in hands/feet \_\_\_\_\_  
 Other: \_\_\_\_\_

**Neurological:** Yes No  
 Headaches \_\_\_\_\_  
 Balance problems \_\_\_\_\_  
 Weakness in arms/legs \_\_\_\_\_  
 Tremors/shaking of hands \_\_\_\_\_  
 Blurred vision \_\_\_\_\_  
 Other: \_\_\_\_\_

**Respiratory:** Yes No  
 Shortness of breath/Breathing problems \_\_\_\_\_  
 Wheezing \_\_\_\_\_  
 Bronchitis/Pneumonia \_\_\_\_\_  
 Tuberculosis \_\_\_\_\_  
 Chronic Cough \_\_\_\_\_  
 Other: \_\_\_\_\_

**Psychiatric:** Yes No  
 Depression \_\_\_\_\_  
 Anxiety \_\_\_\_\_  
 Sleep problems \_\_\_\_\_  
 Chemical Dependence \_\_\_\_\_  
 Other: \_\_\_\_\_

**Gastrointestinal:** Yes No  
 Nausea/Vomiting \_\_\_\_\_  
 Diarrhea \_\_\_\_\_  
 Constipation \_\_\_\_\_  
 Stomach/Abdominal pain \_\_\_\_\_  
 Diverticulitis \_\_\_\_\_  
 Heartburn/Reflux \_\_\_\_\_  
 Other: \_\_\_\_\_

**Other:** Yes No  
 Fever \_\_\_\_\_  
 Broken Bones, please specify \_\_\_\_\_  
 \_\_\_\_\_  
 Joint pain, please specify \_\_\_\_\_  
 \_\_\_\_\_  
 Weight loss/gain \_\_\_\_\_  
 If yes, was loss/gain intentional? \_\_\_\_\_  
 Recent illness, please specify \_\_\_\_\_  
 \_\_\_\_\_

**FOR OFFICE USE ONLY**

Reviewed by \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

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