ORTHOPAEDIC & SPORTS MEDICINE OF ERIE, PC
100 Peach Street, Suite 400
Erie, PA 16507

HEALTH HISTORY FORM

Name _____ **Age** _____ **Height** _____ **Weight** _____
Primary Care Doctor _____ **Pharmacy / Location** _____
Reason for today's visit _____
If injury, how did this occur? _____
Date of injury / Onset? _____ Where? ☐ Home ☐ Work ☐ Other _____
Are you working now? ☐ Y ☐ N Date last worked? _____ Occupation _____
If not working, who released you from work? _____
Describe duties _____

ALLERGIES: ☐ **None** **Other**

☐ Penicillin ☐ Aspirin ☐ Latex ☐ Codeine ☐ Demerol _____
☐ Anesthesia ☐ Morphine ☐ Iodine ☐ Sulfa ☐ Erythromycin _____
☐ Tape / Adhesive _____

CURRENT MEDICATIONS (list dosage and #times taken per day): _____

Are you taking blood thinners? ☐ **Coumadin** ☐ **Pradaxa** ☐ **Xarelto** ☐ **Plavix** ☐ **Lovenox**

YOUR MEDICAL HISTORY: Do you have diabetes, heart disease, high blood pressure, kidney disease? If so, please be sure to check below, along with any other medical history.

☐ Aids	☐ Diabetes	☐ High Cholesterol	☐ Peripheral Vascular Disease
☐ Anemia	☐ Epilepsy / Seizures	☐ Infections	☐ Prostate Disease
☐ Arthritis	☐ Emphysema	☐ Kidney Disease (Describe)	☐ Rheumatic Fever
☐ Back Problems	☐ Gout	☐ Measles / Mumps / Rubella	☐ Shingles
☐ Bleeding Disorder	☐ Heart Disease (Describe)	☐ Meningitis	☐ Sleep Apnea / CPAP? ☐ Y ☐ N
☐ Blood Clots	☐ Heart Murmur	☐ Mental Illness (Describe)	☐ STD / Venereal Disease
☐ Bone Disease	☐ Hepatitis	☐ Migraine Headaches	☐ Thyroid / ☐ Hypo ☐ Hyper
☐ Bronchitis	☐ Hiatal Hernia / Reflux	☐ Neurologic Disease (Describe)	☐ Tuberculosis
☐ Cancer	☐ High Blood Pressure	☐ Osteoporosis / Osteopenia	☐ Ulcers

Other: _____

SURGERIES (Include dates / Location): _____

FAMILY HISTORY:

☐ Bleeding Disorder	☐ Epilepsy / Seizures	☐ High Blood Pressure	☐ Osteoporosis
☐ Cancer	☐ Glaucoma	☐ Kidney Disease	☐ Stroke
☐ Diabetes	☐ Heart Disease (Describe)	☐ Mental Illness (Describe)	☐ Thyroid Disease

Other: _____

SOCIAL HISTORY

Smoke:	Packs daily:	**Alcohol:**	Type:	**Illicit Drug Use: Marijuana**	Type:
	How long:		Amount:	**/Cocaine / Other Drug Use**	Frequency:

Name _____ **Age** _____

REVIEW OF SYSTEMS: Place a check mark in the appropriate blocks in the following list of symptoms:

PROVIDER NOTES

HEAD AND NECK

	Yes	No		Yes	No		Yes	No
Headaches			Ringing in ears			Chronic nose obstruction		
Vision / Glasses			Pain in ears			Chronic sore tongue		
Failing vision			Discharge from ear			Persistent sore gums		
Eye pain			Repeated nose bleeds			Prolonged hoarseness		
Double vision			Teeth problems			Persistent neck rigidity		
See "floating lights"			Frequent colds			Swelling in neck		
Severe hearing loss			Recent URI / Cold					

HEART – CARDIOVASCULAR

	Yes	No		Yes	No		Yes	No
Heart problems			Chest pain on effort			Ankles swell		
Hypertension			Irregular heart beats			Difficult breathing		
Claudication			Chest Pain			Edema		

PULMONARY – LUNGS

	Yes	No		Yes	No		Yes	No
Sit up to breathe easier			Spit up blood			Wheezing		
Chronic cough			Frequent chest colds			Have night sweats		
Shortness of breath			Asthma					

STOMACH AND INTESTINES

	Yes	No		Yes	No		Yes	No
Chronic abdominal pain			Vomit blood			Any blood from rectum		
Persistent nausea			Skin turns yellow			Clay colored stools		
Heartburn			Chronic diarrhea			Habitual constipation		
Appetite loss			Black tarry stools			Have hemorrhoids		
Vomiting			Loss of Bowel Control					

URINARY TRACT

	Yes	No		Yes	No		Yes	No
Frequent urination			Frequent night urination			Passed any stones		
Difficulty urinating			Pain with urination			Retention of urine		
Scanty urination			Leakage of urine					
Blood in urine			Loss of bladder control					

OB / GYN (For women only)

			Yes	No		Yes	No
Age menses started		Missed periods			Painful menstruation		
Length of average cycle		Excess menstruation			Bleed between periods		
Last menstrual period		Number of pregnancies			Number of living children		

MUSCLES – JOINTS

	Yes	No		Yes	No		Yes	No
Physically handicapped / Limited			Tingling sensations			Any paralysis		
Joint or muscle problems			Any numbness			Any shaking		
Shoulder pain			Disturbance in walking			Any strokes		
Back pain			Any muscle jerking			Any seizures		

NEUROPSYCHOLOGICAL

	Yes	No		Yes	No		Yes	No
Depression			Paralysis / weakness			Psychotherapy / counseling		
Nervous breakdown			Any memory loss			Any alcohol problem		
Any mental problem			Personality changes			Any drug problem		
Dizzy spells			Speech disturbances			Serious marital problem		

SKIN

	Yes	No		Yes	No		Yes	No		Yes	No
Rashes			Lesions			Pruritis			Open sores			Redness		

Signature _____ **Date** _____