Patient Health History

ORTHOPEDIC SURGICAL PARTNERS
ORTHO SPEED PASS

Patient Name:_____ **Date:**_____

Date of Birth:_____ **Height:**_____ **Weight:**_____

Primary Care MD: (First & Last name)_____ **Referred By:**_____

Please list all physicians treating you currently:

NAME	SPECIALTY
_____	_____
_____	_____
_____	_____

SYMPTOMS YOU ARE CURRENTLY EXPERIENCING - Check for YES Leave Blank for NO

GENERAL

____ Chills
____ Fainting
____ Fever
____ Headache
____ Recent Weight Loss
____ Night Sweats
____ Numbness

EYES, EARS, NOSE & THROAT

____ Blurred Vision
____ Difficulty Swallowing
____ Double Vision
____ Earache
____ Hoarseness
____ Loss of Hearing
____ Chronic Cough
____ Sinus Pain

GASTROINTESTINAL

____ Poor Appetite
____ Bowel changes
____ Heartburn
____ Nausea
____ Red Blood in Stool
____ Abdominal Pain

CARDIOVASCULAR

____ Chest Pain
____ Ankle Swelling
____ Palpitations
____ Varicose Veins

GENITO-URINARY

____ Bloody Urine
____ Frequency
____ Pain During Urination

SKIN

____ Bruise Easily
____ Itching
____ Skin Sores

MUSCULOSKELETAL / JOINT PAIN

____ Arms
____ Ankle
____ Back
____ Feet
____ Elbow
____ Neck
____ Hip
____ Knee
____ Leg
____ Shoulder
____ Hand
____ Wrist

PAST MEDICAL HISTORY

____ Allergy to Anesthesia
____ Alcoholism
____ Anorexia
____ Anemia
____ Arthritis
____ Asthma
____ Blood Disorder
____ Breast Lump/Mass
____ Cancer-TYPE:_____
____ Cataracts
____ Chemical Dependency
____ COPD
____ Bronchitis
____ Dementia
____ Depression
____ Anxiety
____ Diabetes ___ Type1 ___Type2
____ Diverticulitis
____ Fibromyalgia
____ Gout
____ Glaucoma
____ Heart Disease
____ Atrial Fibrillation
____ Hepatitis
____ Heart Attack
____ High Blood Pressure
____ High Cholesterol
____ Liver Disease
____ MS
____ Pacemaker
____ Stent
____ Pneumonia
____ Pulmonary Embolism
____ DVT
____ Sleep Apnea
____ Stroke
____ TB
____ Thyroid Disease
____ Ulcers
____ GI Bleeding
____ Skin Infection/Cellulitis
____ Hospitalized for Infection

OTHER:_____

THIS IS A 2-SIDED FORM - PLEASE FILL OUT THE BACK OF THIS PAGE →

FAMILY HISTORY

Family History of Pulmonary Embolism/DVT/Blood Clots: ____ NO ____YES Relationship:_____

SOCIAL HISTORY - Please Check YES or NO

Nicotine Use
____ Never
____ Former
____ Current Nicotine Use
TYPE:_____

Alcohol
____ NO
____ YES
____ Drinks Per Day/Week/Month
(circle one)

Drug Use
____ NO
____ YES
Type:_____

PREVIOUS GENERAL SURGERY

Procedure	Year

PREVIOUS ORTHOPEDIC SURGERY

Procedure	Year

PAST JOINT REPLACEMENT SURGERIES

Total Knee Replacement: **RIGHT LEFT**	**Surgeon:**	**Date:**
Total Knee Revision: **RIGHT LEFT**	**Surgeon:**	**Date:**
Total Hip Replacement: **RIGHT LEFT**	**Surgeon:**	**Date:**
Total Hip Revision: **RIGHT LEFT**	**Surgeon:**	**Date:**
Total Shoulder Replacement: **RIGHT LEFT**	**Surgeon:**	**Date:**

I certify that the above information is correct to the best of my knowledge. I will not hold my provider or any members of his or her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature:_____Date:_____