Total Joint Care

PERSONAL HEALTH QUESTIONNAIRE

Please take a few moments to provide the following important information about your current health and clinical history. It will help us provide you with the best possible care. We appreciate it!

Name:________________________________ **Primary Care Doctor:** _____________________________

Referred by: ☐ PCP ☐ Friend ☐ Self ☐ Other: _______________

Reason for visit today:

____

____

____

____

____

Past Medical History
(***please check each box that applies***)

☐ Diabetes
☐ Hypertension
☐ Heart Disease
☐ Heart Murmur
☐ Atrial fibrillation
☐ Pacemaker
☐ High cholesterol
☐ Stroke
☐ Asthma
☐ COPD
☐ Kidney problems
☐ Renal failure/dialysis
☐ Liver disease/hepatitis
☐ Bleeding/Clotting problems
☐ Vascular disease
☐ Gout
☐ Cancer
☐ Epilepsy
☐ Infection (type): _________________
☐ Other: _________________ ☐ Other: _________________ ☐ Other: _________________

Medications/Vitamins/Herbal Supplements
(if have list, give to front desk. Don't need to fill out.)

1. ______________________________________
2. ______________________________________
3. ______________________________________
4. ______________________________________
5. ______________________________________
6. ______________________________________
7. ______________________________________
8. ______________________________________
9. ______________________________________
10. ______________________________________
11. ______________________________________
12. ______________________________________

Medication Allergies ☐ **NONE KNOWN**

☐ Latex ☐ Iodine/ Shellfish
☐ Metals ☐ Penicillin
☐ Sulfa ☐ Lidocaine
☐ Other: ____________ ☐ Other: _______________
☐ Other: ____________ ☐ Other: _______________

Previous Hospitalizations, Surgeries **When?**

1. ____ ______________________
2. ____ ______________________
3. ____ ______________________
4. ____ ______________________
5. ____ ______________________

Social History

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow
Occupation: __________________________________ ☐ Retired
Do you smoke? ☐ Yes ☐ No Chew tobacco? ☐ Yes ☐ No Use recreational drugs? ☐ Yes ☐ No
Do you drink alcoholic beverages? ☐ Socially ☐ Never ☐ Daily

Family History

(Please check any that apply and indicate by (number), family member(s) with same medical history)

Mother(1) Father(2) Mother's Parents(3) Father's Parents(4) Siblings(5) Children(6)

☐ Diabetes _____ ☐ Lung Disease _____ ☐ Alcohol _____ ☐ Drug abuse _____
☐ Cancer _____ ☐ Cardiac _____ ☐ Rheumatoid _____ ☐ Other ___________

Do you or have you had any infectious diseases? ☐ **None**

☐ HIV/AIDS ☐ Hepatitis (Type) ______ ☐ Tuberculosis (When?) ______
☐ Skin / Abdominal / Other (When?) ____

Review of Symptoms: (*Please check all that apply*)

General: ☐ **NONE** ☐ Excessive fatigue ☐ Weakness ☐ Fever ☐ Other: _______

Eye Problems: ☐ **NONE** ☐ Glasses ☐ Cataracts ☐ Glaucoma ☐ Other: ____________

Ear, Nose, Throat: ☐ **NONE** ☐ Poor swallowing ☐ Nose bleeds ☐ Sore throat ☐ Ear pain ☐ Allergies ☐ Hearing loss ☐ Other: ____________________

Cardiovascular: (heart/blood vessel) ☐ **NONE** ☐ High blood pressure ☐ Chest pain ☐ Palpitations ☐ Blood clot ☐ Heart attack ☐ Vascular problems ☐ Other: _______________

Respiratory: ☐ **NONE** ☐ Asthma ☐ Shortness of breath ☐ Bronchitis ☐ Sleep apnea ☐ Pneumonia ☐ Other: _________________

Gastrointestinal: (stomach/intestine) ☐ **NONE** ☐ Heartburn ☐ Nausea ☐ Abdominal pain ☐ Reflux/Ulcers ☐ Constipation ☐ Gallbladder problems ☐ Other:____________

Genitourinary: ☐ **NONE** ☐ Painful urination ☐ Frequent urination ☐ Prostate problems ☐ Frequent UTIs ☐ Blood in urine ☐ Other: _______________

Musculoskeletal: ☐ **NONE** ☐ Joint stiffness ☐ Muscle cramps ☐ Balance problems ☐ Fibromyalgia ☐ Other: ___________________

Integumentary: (skin) ☐ **NONE** ☐ Rash/Itch ☐ Hives ☐ Lupus ☐ Other: __________________

Neurological/ Psychological ☐ **NONE** ☐ Headaches ☐ Memory loss ☐ Seizures ☐ ADD/ADHD ☐ Anxiety ☐ Depression ☐ Stroke ☐ Tremors ☐ Numbness ☐ Other: __________________

Endocrine: ☐ **NONE** ☐ Weight gain ☐ Weight loss ☐ Diabetes ☐ Thyroid Disease ☐ Gout ☐ Liver problems ☐ Other: ____________________

Hematologic: ☐ **NONE** ☐ Bruise easy ☐ Prolonged bleeding ☐ Anemia ☐ Other:______

Reproductive: ☐ **NONE** ☐ Pelvic pain ☐ Heavy bleeding ☐ Cyst ☐ Other: __________
If female, are you pregnant? ☐ Yes ☐ No Date of last period:____

Please describe significant symptoms, medical problems or personal events not marked above:

____
____
____

Thank you for taking the time to provide this important information!

Patient Signature: ________________________________ **Date:** ____________
Legal Guardian or POA Signature: __________________________ **Date:** ____________

I have personally reviewed, confirmed or modified as necessary the above information
Physician Signature: ________________________________ **Date:** ____________