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
Ocupation: _____ ☐ Retired
Do you smoke? ☐ Yes ☐ No Chew tobacco? ☐ Yes ☐ No Use recreational drugs? ☐ Yes ☐ No

Do you drink alcoholic beverages? ☐ Socially ☐ Daily ☐ Never

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:** _____