

PANORAMA ORTHOPEDICS & SPINE CENTER, P.C. – PATIENT HEALTH HISTORY

Patient's Last Name: _____ First: _____ MI: ___ DOB: _____

Primary Care Physician (first & last name): _____

PCP Location: _____ Phone: _____

Referring Physician: _____ Phone: _____

↳ How did you hear about us? _____

PHARMACY PREFERENCE (include location): _____

PLEASE LIST ANY MEDICATION(S) YOU ARE CURRENTLY TAKING:

Please PRINT and include any over the counter medications/supplements and/or pain medications.

PRESCRIPTION MEDICATION(S)

Name of Medication	Dosage	Problem being treated	Date Started	Prescribing Doctor

OVER THE COUNTER MEDICATION(S)/SUPPLEMENTS/VITAMINS/MINERALS

Name of Medication	Dosage	Problem being treated	Date Started	Prescribing Doctor

Do you currently use the following at home? O² (Oxygen) CPAP machine (Sleep Apnea)

HAVE YOU EVER HAD ANY PROBLEMS OR ALLERGIES TO ANY MEDICATION(S)?

YES NO If YES, please list below:

Name of Medication	Type of Reaction

SURGICAL & HOSPITALIZATION HISTORY:

Have you or a family member ever had malignant hyperthermia? YES NO

* Malignant hyperthermia is an inherited disease that causes severe muscle contractions and rise in body temperature when a person is put under general anesthesia.

Have you ever had problems with anesthesia (being numbed or put to sleep)? YES NO

If yes, please list type of problems: _____

Please list any surgeries you have undergone or hospitalizations you have had (including dates):

Surgery/Hospitalization	Date

Patient/Guardian Signature: _____ **Date:** _____

By signing here, I agree that I have completed these forms to the best of my knowledge and ability.

NON MEDICAL ALLERGIES

Are you allergic to any of the following?

- None Adhesive/tape Metal
 Latex Contrast dye Iodine

- Degenerative Joint Disease
 Prosthesis(es) e.g. artificial limb
 Other (including fractures) _____

PAST HEALTH HISTORY

Mark below if you have been diagnosed with any of the following:

Cancer

- Bone cancer
 Breast cancer
 Lung cancer
 Multiple Myeloma
 Prostate cancer
 Other _____

Brain and Nervous System

- Epilepsy
 Seizures
 MS (Multiple Sclerosis)
 Neuropathy
 Alzheimer's Disease
 Parkinson's Disease
 Dementia
 Other _____

Heart and Blood Vessels

- Angina (chest pain)
 Heart Disease/CAD (Coronary Artery Disease)
 Stroke/CVA (Cerebral Vascular Accident)
 Heart Failure
 Blood clot/DVT (Deep Vein Thrombosis)
 Heart Attack/MI (Myocardial Infarction)
 HTN (Hypertension/high blood pressure)
 MVP (Mitral Valve Prolapse)
 High cholesterol
 Dysrhythmia/irregular heartbeat
 Varicose veins/Peripheral Vascular Disease
 Pacemaker
 Other _____

Mental and Emotional Health

- Anxiety, chronic
 Bipolar Disorder
 Depression
 Panic attacks
 Insomnia
 Other _____

Lungs and Respiratory

- Asthma
 COPD (Chronic Obstructive Pulmonary Disease)
Emphysema
 TB (Tuberculosis)
 PE (Pulmonary Embolism/Blood clot in lung)
 Sleep Apnea
 Other _____

Endocrine, Hormones and Metabolic Problems

- Diabetes - Type I
 Diabetes - Type II
 Diabetes - Type unspecified/unknown
 Thyroid Dysfunction
 Hypothyroidism (underactive thyroid)
 Hyperthyroidism (overactive thyroid)
 Other _____

Stomach and Digestive

- GERD
 Hepatitis - Type A
 Hepatitis - Type B
 Hepatitis - Type C
 Hepatitis - Type unspecified/unknown
 Peptic ulcer
 Reflux
 Stomach ulcer
 Hernia
 Hiatal hernia
 Other _____

Blood and Lymph Node Problems

- Anemia
 Hemophilia
 Sickle Cell Disease/Anemia
 Edema
 Blood transfusion
 Other _____

Kidneys and Urinary Tract

- Renal failure
 Renal insufficiency
 Chronic Kidney Disease
 UTI (Urinary Tract Infection)
 Other _____

Immune/Autoimmune and Infectious Problems

- AIDS
 HIV positive
 Lupus
 Rheumatoid Arthritis
 Other _____

Bones, Joints and Muscles

- Arthritis
 Gout
 Osteoporosis
 Fibromyalgia
 Scoliosis

Eyes, Ears, Nose, Mouth and Throat

- Glaucoma
 Cataracts
 Macular Degeneration
 Blind
 Deaf
 Hearing loss
 Other _____

Genitourinary

Females: Currently pregnant

Other Problems Previously Diagnosed _____

FAMILY HISTORY

Have any family members been diagnosed with the following?

- Family history unknown Heart Disease
 Anesthesia problems Arthritis
Osteoporosis Bleeding/clotting problem
 Diabetes Cancer _____
 No significant family health history

SOCIAL HISTORY

Current type of work/occupation _____

Current use of any of the following tobacco products

- None Cigarettes Cigars
 Smokeless Tobacco

How many cigarettes do you smoke in an average day?

- <1 cigarette 1-5 cigarettes ½ pack 1 pack
 1 ½ packs 2 packs 3+ packs
 Other _____

History of use any of the following tobacco products

- None Cigarettes Cigars
 Smokeless Tobacco

Date stopped _____

History of or current use of alcoholic beverages

(A drink is one shot of liquor or one glass of wine, or one bottle/can of beer)

- None
 Abstainer (fewer than 12 drinks per year)
 Light drinker (1-13 drinks per month)
 Moderate/"Social" drinker (4-14 drinks per week)
 Heavy drinker (more than 2 drinks per day)
 Binge drinker (drinks intermittently: 5 or more drinks/session)
 History of Alcoholism

Current use of any of the following drugs

- None Morphine Cocaine Meth
 Heroin Medical Marijuana Marijuana
 Other _____

History of or current drug dependency or addiction

- None Morphine Marijuana Meth
 Heroin Cocaine Diazepam (Valium)
 Soma Pain Medication _____
 Other _____
 Prednisone/steroids _____

Do you live alone?

- Yes No

Which is your dominant hand?

- Right Left Ambidextrous/neither

REVIEW OF CURRENT SYMPTOMS

Do you currently have/recently had any of the following?

General Health

- Dizziness (Syncope)
 Night sweats
 Fever
 Unintentional weight loss/gain (circle one)

Ears, Nose, Mouth and Throat

- Hearing loss
 Ringing in ears

Heart and Blood Vessels

- Blacking out or fainting
 Chest pain

Lungs and Respiratory

- Shortness of breath or difficulty breathing

Stomach and Digestive

- Blood in stool
 Gastrointestinal bleeding
 Heartburn
 Constipation
 Diarrhea

Kidneys and Urinary Tract

- Unable to control bladder or bowel (circle one)
 Increased frequency of urination

Bones, Joints and Muscles

- Back pain
 Painful joints
 Swelling of joints
 Muscle weakness

Glands, Hormones and Blood Sugar Control

- Increased thirst

Blood & Lymph Nodes

- Bleeds excessively after injury
 Bruises easily

Allergies

- Non-medical allergies (food, etc.) _____

Patient/Guardian Signature: _____

Date: _____

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