PANORAMA
Orthopedics & Spine Center

Patient Health History

Today's Date: _____ Appointment Date: _____

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

Primary Care Physician (first & last name):_____

PCP Location: _____ Phone: _____

Referring Physician: _____ Phone: _____

Employer: _____ Occupation: _____

Pharmacy Preference (include location): _____

MEDICATIONS — Please list any medication(s) you are currently taking, include prescribed medications, vitamins, supplements and over-the-counter medications

Medication	Dosage/Directions	Problem being treated	Prescribing doctor

ALLERGIES — Please list all medical allergies and tell us how you react to them

Allergy	Reaction

Are you allergic to latex? ☐ **Yes** ☐ **No**

Are you allergic to adhesive/tape? ☐ **Yes** ☐ **No**

Are you allergic to contrast dye? ☐ **Yes** ☐ **No**

Are you allergic to Iodine or Betadine ☐ **Yes** ☐ **No**

Are you allergic to metal? ☐ **Yes** ☐ **No**

Are you allergic to birds/feathers/eggs? ☐ **Yes: _____** ☐ **No**

PAST MEDICAL HISTORY — Check all conditions you have now, or have had in the past

CANCER

☐ Type:_____

CARDIOVASCULAR (heart & blood vessels)

☐ Angina (chest pain)
☐ Arrhythmia/Irregular heartbeat
☐ Blood clot/DVT (deep vein thrombosis)
Date Occurred:_____
☐ Heart disease/Coronary Artery disease
☐ High Cholesterol/Hyperlipidemia
☐ MVP (mitral valve prolapse)
☐ Pacemaker
☐ Varicose veins/Peripheral Vascular disease
☐ Hypertension/High blood pressure
☐ Stent- Date Occurred:_____
☐ AICD (Automatic Implantable Cardioverter Defibrillator)

PULMONARY (lungs & respiratory)

☐ Asthma
☐ COPD (chronic obstructive pulmonary disease)
☐ PE (pulmonary embolism/blood clot in lung)
Date Occurred: _____
☐ Sleep Apnea
☐ TB (tuberculosis)

GENITOURINARY (kidneys & urinary tract)

☐ Renal failure
☐ Renal insufficiency
☐ UTI (urinary tract infection)
☐ Currently pregnant

GASTROINTESTINAL (stomach & digestive)

☐ Gastric Ulcer
☐ GERD
☐ Hepatitis A
☐ Hepatitis B
☐ Hepatitis C
☐ Hepatitis—type unknown
☐ Hernia
☐ Peptic Ulcer
☐ Liver disease

NEXT PAGE PLEASE

BONES, JOINTS & MUSCLES

- ☐ Arthritis
- ☐ Degenerative Joint disease
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Osteoporosis
- ☐ Scoliosis

PSYCHIATRIC DISORDER (mental health)

- ☐ Anxiety
- ☐ Bipolar disorder
- ☐ Depression

HEENT (head, ears, eyes, nose & throat)

- ☐ Blind
- ☐ Deaf
- ☐ Hearing loss

NEUROLOGIC DISORDER (brain & nervous sys)

- ☐ Alzheimer's disease
- ☐ Dementia
- ☐ MS (Multiple Sclerosis)
- ☐ Parkinson's disease
- ☐ Seizure Disorder
- ☐ Stroke/CVA- Date Occurred: _____
- ☐ Myasthenia gravis
- ☐ Muscular dystrophy

HEMATOLOGIC (blood & lymph node)

- ☐ Anemia
- ☐ Edema
- ☐ Lupus
- ☐ Hemophilia
- ☐ Sickle cell disease
- ☐ Clotting Disorders

METABOLIC (endocrine, hormones & metabolic)

- ☐ Diabetes—Type I
- ☐ Diabetes—Type II
- ☐ Diabetes—Type unknown
- ☐ Thyroid dysfunction
  - ☐ Hypothyroidism
  - ☐ Hyperthyroidism

IMMUNE/AUTOIMMUNE & INFECTIOUS PROBLEMS

- ☐ AIDS
- ☐ HIV positive
- ☐ Rheumatoid Arthritis
- ☐ MRSA (Methicillin Resistant Staph Aureus)

OTHER MEDICAL CONDITIONS NOT LISTED ABOVE: _____

_____

PAST SURGICAL HISTORY — Check all that apply and indicated which side R/L as appropriate

- ☐ ACL surgery: year_____ R/L
- ☐ Angioplasty
- ☐ Angio w/stent
- ☐ Appendectomy
- ☐ Arthroscopy ankle: year_____ R/L
- ☐ Arthroscopy elbow: year_____ R/L
- ☐ Arthroscopy hip: year_____ R/L
- ☐ Arthroscopy knee: year_____ R/L
- ☐ Arthroscopy wrist: year_____ R/L
- ☐ Arthroscopy shoulder: year_____ R/L
- ☐ Back surgery: year_____
- ☐ CABG: year _____
- ☐ Carpal tunnel release: year_____ R/L
- ☐ Cataract extraction
- ☐ Cholecystectomy
- ☐ Colectomy
- ☐ Colostomy
- ☐ Gastric bypass
- ☐ Hernia repair
- ☐ Hip replacement: year_____ R/L
- ☐ Knee replacement: year_____ R/L
- ☐ Laminectomy: year_____
- ☐ LASIK
- ☐ Meniscus surgery: year_____ R/L
- ☐ ORIF: year_____
- ☐ Pacemaker
- ☐ Rotator cuff repair: year_____ R/L
- ☐ Small bowel resection
- ☐ Tonsillectomy
- ☐ Thyroidectomy
- ☐ Transplant: _____

GENDER SPECIFIC ☐ Tubal ligation ☐ Cesarean section ☐ Mastectomy ☐ Hysterectomy

☐ **OTHER SURGURIES NOT LISTED ABOVE:** _____

☐ **FRACTURES:** _____

☐ **PROBLEMS WITH PAST ANESTHESIA (IF YES, PLEASE LIST):**_____

☐ **CURRENTLY BEING TREATED WITH:** ☐ Dialysis ☐ Chemotherapy ☐ Radiation ☐ Oxygen (Day/Night) _____ # of liters

FAMILY HISTORY — Check the boxes below if any **blood** relative has been diagnosed with any of the following?

	Relationship		Relationship
☐ Anesthesia problems	_____	☐ Osteoporosis	_____
☐ Arthritis	_____	☐ Diabetes	_____
☐ Bleeding/clotting problems	_____	☐ Family history unknown	
☐ Cancer: type: _____	_____	☐ No significant family history	

SOCIAL HISTORY

HAND DOMINANCE

- ☐ Right
- ☐ Left
- ☐ Ambidextrous

DO YOU DRINK ALCOHOL?

- ☐ Yes
- ☐ No

What kind & how much?

_____

_____

DO YOU USE TOBACCO?

- ☐ Yes
  Type of tobacco: _____
- ☐ No
- ☐ Former
  Type of tobacco: _____
  Age quit: _____

CURRENT/FORMER ILLICIT DRUG USE

- ☐ None
- ☐ Current
  What kind? _____
- ☐ Former
  What kind? _____
  Date quit: _____

Patient/guardian signature: _____ DOB:_____ Today's Date:_____