GROSSKOPF ORTHOPEDICS, S.C.
Health History

NAME: _____TODAY'S DATE: _____

DATE OF BIRTH: _____ AGE: _____ HEIGHT: _____ WEIGHT: _____

Allergies: _____

_____

Medications, Vitamins, Supplements

Name: _____ Dosage: _____

Name: _____ Dosage: _____

Name: _____ Dosage: _____

Name: _____ Dosage: _____

Illnesses (indicate if you have history of or currently have this illness)

Stroke or TIA	Depression	Pneumonia
Heart Attack	Panic Attack	Asthma
Heart Murmur	Epilepsy	Tuberculosis
High Blood Pressure	Reflux (Gerd)	Diabetes
High Cholesterol	Ulcers	Cancer
DVT or Blood Clots	Hypothyroid	Enlarged Prostate
Bleeding Tendencies	Kidney Disease	HIV
Anemia	Kidney Stones	Rheum Arthritis
Hepatitis	Gall Stones	Arthritis / DJD
Pace Maker	Hyperthyroid	Osteoporosis

Past Medical History

Surgeries / Hospitalizations	Year	Complications

Have you ever had general anesthesia? Yes___ No___
Have you had any problems with anesthesia? Yes___ No___ Describe: _____

Social History *(check all that apply)*

Employment Status:

FT___ PT___ Occupation: _____ Homemaker ___ Student ___ Retired ___

Do you live in a Nursing Home / Assisted Living facility? Yes ___ No ___ Facility: _____

Single ___ Married ___ Divorced ___ Separated ___ Widowed ___

Children: No __ Yes ___ # of children ____ Do you live alone? Yes ___ No ___

Exercise: Daily __ Weekly __ Monthly ___ Rarely __ Never __ Exercise Type: _____

History of substance abuse: Yes ___ No ___ If yes, what type: _____

Smoking: No __ Yes __ # packs/day ____ for ____ years. Quit Smoking: No __ Yes __ Quit Date:_____

Drink alcohol: none ____ daily ___ 1-2x/wk ___ 1-2x/mo ___ 1-2x/yr ___

Family History

Is there an immediate family history of the following conditions?
Cancer ___ Heart Disease___ Hypertension ___ Osteoarthritis___ Blood Disorders ___

Review of Systems (indicate Current conditions)

Weight Loss	Swelling of feet	Morning stiffness
Chills	Palpitations	Weakness
Fever	Chest pain/discomfort	Frequent Itching
Fatigue	Difficulty breathing at night	Rashes
Loss of energy	Nausea	Skin Cancer
Double vision	Vomiting blood	Easy bleeding
Worsening vision	Change in bowel habits	Easy bruising tendency
Loss of hearing	Blood in the stool	Numbness
Nosebleeds	Laxatives	Seizures
Hoarseness	Heartburn	Memory Loss
Hay Fever	Difficult urination	Balance Problems
Seasonal allergies	Pain on urination	Persistent Worry
Shortness of breath w/exertion	Blood in urine (Hematuria)	Anxious/Nervous
Fast heart rate	Increased urinary frequency	Unhappy or Depressed
Palpitations	Loss of urine when coughing	Other: _____
Shortness of breath (in general)	Joint swelling, localized	Other: _____

Women Only: Are you pregnant? Yes ___ No___ Last Menses: _____

PATIENT NAME *(please print)*: _____

Patient Signature: _____ DATE: _____

Reviewed by: _____ *Date:* _____