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
__Chills
__Fever
__Fatigue
__Loss of energy
__Double vision
__Worsening vision
__Loss of hearing
__Nosebleeds
__Hoarseness
__Hay Fever
__Seasonal allergies
__Shortness of breath w/exertion
__Fast heart rate
__Palpitations
__Shortness of breath (in general)

__Swelling of feet
__Palpitations
__Chest pain/discomfort
__Difficulty breathing at night
__Nausea
__Vomiting blood
__Change in bowel habits
__Blood in the stool
__Laxatives
__Heartburn
__Difficult urination
__Pain on urination
__Blood in urine (Hematuria)
__Increased urinary frequency
__Loss of urine when coughing
__Joint swelling, localized

__Morning stiffness
__Weakness
__Frequent Itching
__Rashes
__Skin Cancer
__Easy bleeding
__Easy bruising tendency
__Numbness
__Seizures
__Memory Loss
__Balance Problems
__Persistent Worry
__Anxious/Nervous
__Unhappy or Depressed
__Other: ____________________
__Other: ____________________

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

PATIENT NAME ***(please print)*****:** ____

Patient Signature**:** ____________________________________ **DATE:** _____________

Reviewed by: ____ *Date:* _______________________