

LAKES ORTHOPAEDIC SPECIALISTS P.A.

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GENERAL HEALTH HISTORY

NAME: _____ PERSONAL PHYSICIAN: _____

ILLNESS: Have you ever had:

	Yes	No	Required Treatment	Required Hospitalization	Comments
Sleep Apnea	___	___	___	___	
High Blood Pressure	___	___	___	___	
Heart Disease	___	___	___	___	
Diabetes	___	___	___	___	
Asthma	___	___	___	___	
Pneumonia	___	___	___	___	
Blood Clots	___	___	___	___	
Ulcer	___	___	___	___	
Kidney Disease	___	___	___	___	
Anemia	___	___	___	___	
Seizures	___	___	___	___	
Liver Disease/Hepatitis	___	___	___	___	
Fibromyalgia	___	___	___	___	

PAST SURGERIES: _____

<u>CURRENT MEDICATIONS:</u>	<u>Dose:</u>	<u>Times Each Day:</u>	<u>CURRENT MEDICATIONS:</u>	<u>Dose:</u>	<u>Times Each Day:</u>
1.			7.		
2.			8.		
3.			9.		
4.			10.		
5.			11.		
6.			12.		

ALLERGIES TO MEDICATIONS: Yes No What: _____ Reaction: _____

SOCIAL HISTORY:

Marital Status: ___ Single ___ Married ___ Divorced ___ Separated ___ Widow(er)

Occupation: _____

Living: I live in a Home: _____ Apt. _____ Retirement Complex _____ Other _____

I live With Spouse: _____ Alone _____ Other _____

Habits: Yes No Smoke Packs per day _____ How many years _____

Yes No Alcohol Average consumption per week _____

Yes No Coffee Cups per day _____

FAMILY HISTORY: _____

REVIEW OF SYSTEMS:

	<u>Yes</u>	<u>No</u>	<u>(If Yes, please circle – Current Symptoms Only)</u>
1.	___	___	Fevers, chills, sweats.
2.	___	___	Loss of appetite, loss of weight.
3.	___	___	Chest pain, shortness of breath, rapid or irregular heart beat, swollen ankles, fainting spells.
4.	___	___	Persistent cough, cough up blood, difficulty breathing, emphysema, pneumonia, TB.
5.	___	___	Heart burn, ulcer, vomited blood, jaundice, hepatitis.
6.	___	___	Bladder infection, kidney stones, blood in urine.
7.	___	___	Headache, dizzy spells, seizures, stroke, head injury.
8.	___	___	Rheumatoid arthritis, gout, lupus.
9.	___	___	Depression, nervous breakdown.
10.	___	___	Thyroid trouble, elevated blood sugar.
11.	___	___	Anemia, blood clots, bleeding problems, phlebitis.
12.	___	___	Cancer: (Type) _____