INTEGRITY ORTHOPEDICS

Patient Health History

In order for us to obtain a complete medical history, it is important for you to fill out this form as complete as possible. This is very important information. Please fill out every item. This information will be entered into the computer and you are welcome to a copy of the report if you wish.

PATIENT'S LAST _____ **FIRST** _____ **MI** ____

SEX ____ **Male** ____ **Female** **DATE OF BIRTH:** _____ **HT:** _____ **WT:** _____ **lbs**

RACE Circle: ***American Indian/Alaskan Native*** ***Asian*** ***Black/African American*** ***White*** ***Hispanic/Latino/Spanish***

LANGUAGE (Preferred): _____ **E-MAIL (Adults)** _____

PRIMARY PHYSICIAN NAME: _____ **PHONE:** _____

PHARMACY NAME with LOCATION: _____

REASON FOR TODAY'S VISIT: _____

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING, IF YOU HAVE A LIST ATTACH TO FORM

NAME OF MEDICATION	DOSAGE	HOW OFTEN TAKEN

MEDICATION ALLERGIES:

NAME OF MEDICATION	TYPE OF REACTION

HAVE YOU RECEIVED A FLU VACCINATION WITHIN THE LAST YEAR? YES or NO

HAVE YOU EVER HAD ANY PROBLEMS WITH ANESTHESIA (being numbed or put to sleep)? YES or NO
If yes, describe _____

LIST SURGERIES (BONES, JOINTS, MUSCLES) WITH DATES:

_____

_____

LIST ALL OTHER SURGERIES WITH DATES:

_____

_____

HAVE YOU EVER BEEN HOSPITALIZED FOR *NON-SURGICAL* REASONS? YES or NO, If yes, please list hospitalizations with dates: _____

_____

HAVE YOU FALLEN WITHIN THE LAST YEAR? YES or NO, If yes when? _____