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 Circle: 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 _____ **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

ARE YOU ALLERGIC TO ANY MEDICATIONS ___YES ___ NO – If yes, please list below

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? _____

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 NAME _____

Have you had a flu vaccination in the last year? No ☐ Yes ☐ If yes, when? _____(dd/mm/yyyy)

Are you a current smoker? No ☐ Yes ☐ Are you a former smoker? No ☐ Yes ☐

If you are female and between the ages of 50-74, please check if you have had any of the following:
Bilateral Mastectomy ☐ Mastectomy of left breast ☐ Mastectomy of right breast ☐
Mammogram in the past year? When? _____ (mm/yyyy)

If you are 65 years old or older, have you had a pneumonia vaccination?
No ☐ Yes ☐ If yes, when? _____ (year)

Patient Health History

Marking Instructions

- Use only a number 2 pencil.
- Fill in the complete oval as shown below.

Correct Mark ● Incorrect Marks ⊘ ✓ ✗

3 - 5 8 2 3 9 5

DIRECTION OF FEED

Name: _____

Date of Appt: _____

1. Are you allergic to any of the following?

	Yes		Yes
Adhesive tape	○	Metal	○
Iodine	○	Contrast Dye	○
Latex	○		

2. Mark if you have been diagnosed with any of the following:

	Yes		Yes
Bone Cancer	○	Duodenal Ulcer	○
Breast Cancer	○	Hepatitis, unspecified type	○
Colon Cancer	○	Hepatitis, specified type	○
Lung Cancer	○		
Prostate Cancer	○	Arthritis, unspecified type	○
Other Cancer	○	Arthritis, Osteo	○
		Arthritis, Rheumatoid	○
Heart Attack	○		
Heart Disease	○	Anxiety	○
Hypertension	○	Depression	○
Stroke	○		
		Diabetes	○
Asthma	○		
Tuberculosis	○	Anemia	○

3. Mark family members who have been diagnosed with any of the following:

	None	Mother	Father	Brother	Sister
Heart Disease	○	○	○	○	○
High Blood Pressure	○	○	○	○	○
Stroke	○	○	○	○	○
Asthma	○	○	○	○	○
COPD	○	○	○	○	○
Arthritis	○	○	○	○	○
Osteoporosis	○	○	○	○	○
Diabetes before age 18	○	○	○	○	○
Diabetes after age 18	○	○	○	○	○
Bleeding/Clotting Problem	○	○	○	○	○

4. Mark if retired: ○ Yes

5. Mark marital status: ○ Single ○ Separated ○ Married ○ Widowed ○ Divorced

6. Do you currently use any of the following?

Tobacco Products ○ None ○ Cigarettes ○ Smokeless Tobacco ○ Cigars

Give the closest amount of cigarettes you smoke in an average day. ○ 1 pack ○ 2 packs ○ 1 1/2 packs ○ 3 packs

Alcoholic Beverages -

A drink is 1 shot of liquor or 1 glass of wine or 1 bottle/can of beer.

○ abstainer (less than 12 drinks/yr)
○ light (1-13 drinks/mo)
○ moderate (4-14 drinks/wk)
○ heavy (>2 drinks/day)

7. Dependency or addiction to drugs now or in the past:

○ Amphetamines	○ Hydrocodone
○ Barbiturates	○ Marijuana
○ Cocaine	○ Morphine
○ Codeine	○ Oxycodone
○ Diazepam	○ Soma
○ Heroin	

8. Do you now have or have you recently had any of the following?

	Yes	No
fatigue	○	○
fever	○	○
unintentional weight gain	○	○
unintentional weight loss	○	○
blurred vision	○	○
red eye	○	○
sensitivity to light	○	○
blacking out or fainting	○	○
chest pain	○	○
irregular heartbeats	○	○
frequent productive cough	○	○
shortness of breath	○	○
wheezing	○	○
abdominal pain	○	○
nausea	○	○
vomiting	○	○
cramping	○	○
pain in back	○	○
pain in neck	○	○
painful joints	○	○
stiffness in joints	○	○
weakness	○	○
change in alertness	○	○
drooping of one side of face	○	○
headache	○	○
loss of consciousness	○	○
pain, facial severe	○	○
seizures	○	○
tingling	○	○
feels nervous (anxiety)	○	○
feels sad (depressed)	○	○
trouble sleeping	○	○
appetite is increased	○	○
fatigue (excessive)	○	○
neck has enlarged	○	○
thirst is increased	○	○
infections recurring	○	○
reaction to an insect bite or sting (severe)	○	○

582395

582395

Covid -19 Questionnaire

Name: _____ Date: _____

Please Wash Hands or Use Hand Sanitizer upon entering and leaving

1. Have you traveled outside or been in contact with anyone that has been out of the US in past 30 days? Yes ☐ No ☐
   If yes, please list the countries you or they have visited:

   _____

2. Have you been in close contact, in the past 30 days, with an individual who has had any of these symptoms. Yes ☐ No ☐

   ☐ Fever over 99.0° F
   ☐ Persistent cough
   ☐ Shortness of breath/chest tightness
   ☐ Sore throat/ Loss of taste or smell

   If yes, have they been diagnosed and/or seen the doctor? Yes ☐ No ☐

   _____

3. Have you had any of these symptoms? Yes ☐ No ☐
   ☐ Fever over 99.0° F
   ☐ Persistent cough
   ☐ Shortness of breath/chest tightness
   ☐ Sore throat/ Loss taste or smell

   If yes, how long have you had these symptoms? _____
   If yes, have you been diagnosed and/or seen the doctor? Yes ☐ No ☐

   _____

4. Have you been on Airplane or a Close gathering of people greater than 10 persons within the last 30 days?
   Yes ☐ No ☐
   If yes please explain _____

5. Have you been compliant with the social distancing/Mask orders that has been instituted by the Governor and/or Local officials?
   Yes ☐ No ☐

6. Are you or have you had direct/indirect contact with a Healthcare/Essential worker that has not been using PPE while at work?
   Yes ☐ No ☐

7. Have you been contacted by a public health official that you may have been exposed to Covid-19? Yes ☐ No ☐