Denali Orthopedic Surgery, P.C.
Health History Questionnaire

In an effort to serve you better, we request you please provide us with the following information. This information helps us provide you with the best care and treatment possible. Please keep in mind **all information is held strictly confidential.** Thank you for your time.

Name: ______________________________ **Date:** ____________ **Age:** ____________
Reason/Chief Complaint for Consultation: □ Left □ Right ______________________________
Date of Injury or Onset: ____________ **Height:** _______ **Weight:** _______ **Dominate Hand:** □ Left □ Right
Family Physician: ______________________________ **Pharmacy:** ______________________

Patient Present/Past Medical History

Please list any medical conditions (e.g., Heart Disease, Stroke, Cancer, Diabetes, Blood Clots, Ulcers, etc.) you are currently being treated for or have been treated for in the past.

____
____
____

Are you enrolled in a pain management program? □ Yes □ No If Yes, physician name? ____________

Surgical History

Type of Surgery	Date

Have you or any of your family members ever experienced any problems with anesthesia? □ Yes □ No
(If yes, please indicate problems experienced with anesthesia) ______________________________

Current Medications ☐ None

(Please list prescription medications, over-the-counter medications, and vitamins)

Medication____________________Dose______________Frequency______________
Medication____________________Dose______________Frequency______________
Medication____________________Dose______________Frequency______________
Medication____________________Dose______________Frequency______________

Drug Allergies ☐ None

Medication ____________________Type of Reaction____________________
Medication ____________________Type of Reaction____________________
Medication ____________________Type of Reaction____________________

Are you allergic to latex products? □ Yes □ No **Are your immunizations current?** □ Yes □ No

Family Medical History

(List any family history for significant conditions such as Heart Disease, Hypertension/High Blood Pressure, Stroke, Diabetes, Cancer, Rheumatoid Arthritis, etc.)

Father: ____ Deceased □ Yes
Mother: ____ Deceased □ Yes
Sibling(s): ____ Deceased □ Yes

Social History

Marital Status: □ Married □ Single □ Widowed □ Divorced **Occupation**: ______________________________

Who do you live with? ____

□ Yes □ No **Tobacco/Cigarette Use** If yes, packs/times per day? __________ Number of years ________

□ Yes □ No **Pipe/Cigar/Chew Use** If yes, how many times per day? _______ Number of years________

□ Yes □ No **Alcohol Use** **Type**: □ Beer □ Wine □ Liquor **# of drinks per week** _________

If yes, do you drink daily? □ Yes □ No

□ Yes □ No **Marijuana/Cocaine/Other Drug Use** **Type:** _________________ **Frequency:** ________________

Review of Systems

(Indicate any symptoms you have experiences in the last three months)

Constitutional

YES	NO	
□	□	Fever
□	□	Chills
□	□	Weight Loss
□	□	Night Sweats

Neurological

YES	NO	
□	□	Headaches
□	□	Numbness
□	□	Weakness
□	□	Seizures
□	□	Vertigo/Dizziness
□	□	Lack of Coordination
□	□	Loss of Balance
□	□	Stroke
□	□	Other: ______________

Eyes

YES	NO	
□	□	Glasses/Contacts
□	□	Vision Loss
□	□	Other: ______________

Ears/Nose/Throat/Mouth

YES	NO	
□	□	Hearing Loss/Disorders
□	□	Dentures
□	□	Sore Throat
□	□	Other: ______________

Cardiovascular

YES	NO	
□	□	Chest Pain/Heart Attack
□	□	History of Blood Clots
□	□	Swelling of Ankles/Feet
□	□	Poor Circulation
□	□	Heart Palpitations
□	□	High Blood Pressure
□	□	Heart Disease
□	□	Other: ______________

Respiratory

YES	NO	
□	□	Asthma
□	□	Shortness of Breath
□	□	Recent Cold/Flu
□	□	Coughing up Blood
□	□	Other: ______________

Gastrointestinal

YES	NO	
□	□	Indigestion
□	□	Ulcers
□	□	Black/Bloody Stools
□	□	Liver Disease/Hepatitis
□	□	Other: ______________

Genitourinary

YES	NO	
□	□	Painful Urination
□	□	Urgency to Urinate
□	□	Blood in Urine
□	□	Decrease in Urine Flow
□	□	Urinary Infection
□	□	Other: ______________

Women Only

YES	NO	
□	□	Currently Pregnant
□	□	Date of Last Menstrual Period? ______________

Musculoskeletal

YES	NO	
□	□	Fracture/Broken Bone
□	□	Joint Pain/Swelling
□	□	Muscle Weakness
□	□	Gout
□	□	Arthritis
□	□	Musculoskeletal Pain- Location? ____________
□	□	Other: ______________

Skin

YES	NO	
□	□	Eczema/Psoriasis
□	□	Rash
□	□	Ulcer
□	□	Other: ______________

Psychiatric

YES	NO	
□	□	Depression
□	□	Anxiety
□	□	Mental Illness
□	□	Other: ______________

Allergy/Immunologic

YES	NO	
□	□	Poor Healing
□	□	Persistent infection
□	□	Exposure to HIV
□	□	Exposure to TB
□	□	Exposure to Hepatitis
□	□	Other: ______________

Hematologic/Lymphatic

YES	NO	
□	□	Swollen Glands/Nodes
□	□	Anemia
□	□	Bleeding Disorder
□	□	Blood Transfusion(s)
□	□	Other: ______________

Endocrine

YES	NO	
□	□	Cold/Heat Intolerance
□	□	Diabetes
□	□	Thyroid Disorder
□	□	Other: ______________

____ ____________________

Patient Signature (Parent if Minor Patient) **Date**

____ ____________________

Physician Signature **Date**