



# Hess Orthopaedics and Sports Medicine, PLC

## Medical History

**Past Medical History:** Have you ever had any of the following? Check all that apply and provide explanation:

- Cancer     Neurological Disease     Blood Clots     Rheumatoid Arthritis     Asthma  
 AIDS/HIV     Autoimmune Disorder     Heart Disease     Anxiety/Depression  
 Gout     High Blood Pressure     Kidney Disease     Bleeding Disorder  
 Stroke     Circulation Problems     Blood Transfusions     Stomach Ulcer / Heartburn  
 Diabetes     Liver Disease/Hepatitis     Thyroid Disease     Major Infection  
 Malignant Hyperthermia     Lung Disease     Other: \_\_\_\_\_

Have you or family member ever had a reaction to anesthesia?  No     Yes, please explain: \_\_\_\_\_

Are you allergic to latex?  No     Yes, please explain: \_\_\_\_\_

**Surgical History:**

Month / Year	Description

Month / Year	Description

**Social History:**

Occupation: \_\_\_\_\_ Are you pregnant?  Yes     No    How many children do you have? \_\_\_\_

Marital Status:  Single     Married     Other

Do you smoke/use tobacco?  Yes     No    How much? \_\_\_\_\_ In the past?  Yes     No    How long? \_\_\_\_\_

Do you drink alcoholic beverages?  Yes     No    In the past? \_\_\_\_\_ Type/Weekly Amount? \_\_\_\_\_

	Major Medical Problems	Age of Death	Cause of Death
Father			
Mother			
Siblings			
Children			

Family History of:  Rheumatoid Arthritis     Diabetes     Heart Disease     Clotting Problems     Malignant Hyperthermia

**Allergies:**

Allergic to:	Reaction	Allergic to:	Reaction

**Medications:** Please include all medications, including vitamins, herbal and over the counter.

Medication	Dose	Frequency

Medication	Dose	Frequency

**OFFICE USE ONLY:** Provider: \_\_\_\_\_

Reviewed On: \_\_\_\_\_



# Hess Orthopaedics and Sports Medicine, PLC

## Review of Systems

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Do you now, or have you had, any problems related to the following systems? Circle YES or NO

### Constitutional Symptoms

Fever YES NO  
 Chills YES NO  
 Headache YES NO  
 Other: \_\_\_\_\_

### Integumentary

Skin Rash YES NO  
 Boils YES NO  
 Persistent Itch YES NO  
 Other: \_\_\_\_\_

### Eyes

Blurred Vision YES NO  
 Double Vision YES NO  
 Pain YES NO  
 Other: \_\_\_\_\_

### Musculoskeletal

Joint Pain YES NO  
 Neck Pain YES NO  
 Back Pain YES NO  
 Other: \_\_\_\_\_

### Allergic / Innumologic

Hay Fever YES NO  
 Drug Allergies (Please list) YES NO  
 Other: \_\_\_\_\_

### Ear/Nose/Throat/Mouth

Ear Infection YES NO  
 Sore Throat YES NO  
 Sinus Problems YES NO  
 Other: \_\_\_\_\_

### Neurological

Tremors YES NO  
 Dizzy Spells YES NO  
 Numbness/tingling YES NO  
 Other: \_\_\_\_\_

### Respiratory

Wheezing YES NO  
 Frequent Cough YES NO  
 Shortness of Breath YES NO  
 Other: \_\_\_\_\_

### Endocrine

Excessive Thirst YES NO  
 Too Hot/Cold YES NO  
 Tired/Sluggish YES NO  
 Other: \_\_\_\_\_

### Hematologic/Lymphatic

Swollen Glands YES NO  
 Blood Clotting Problem YES NO  
 Other: \_\_\_\_\_

### Cardiovascular

Chest Pain YES NO  
 Varicose Veins YES NO  
 High Blood Pressure YES NO  
 Other: \_\_\_\_\_

### Psychologic

Are you generally satisfied with your life? YES NO  
 Do you feel severely depressed? YES NO  
 Have you considered suicide? YES NO  
 Other: \_\_\_\_\_

Please explain any YES answers:

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

### OFFICE USE ONLY

Provider: \_\_\_\_\_

Reviewed On: \_\_\_\_\_