Orthopedic Trauma Health History Questionnaire:

FIRST PHYSICIANS GROUP
of Sarasota Memorial Health Care System

Name____ Date of birth_________________________

Address____

Local phone number________________________ Alternative phone number__________________

Please describe what problem or concern brought you to our office today:

☐ Initial Consult ☐ Post-Op Appointment

☐ Referring Physician_______________________________________

Personal Health History		Previous Surgical Procedures	
Please check past(P) or current(C) problems or conditions		Please check if you have had any of the following	
		Procedure	Year
P☐ C☐ Hypertension	P☐ C☐ Atrial Fibrillation	☐ Heart surgery	
P☐ C☐ High cholesterol	P☐ C☐ Stomach ulcer	☐ Carotid artery surgery	
P☐ C☐ Diabetes	P☐ C☐ Seizures	☐ Vascular surgery / stent	
P☐ C☐ Heart attack or angina	P☐ C☐ Headaches	☐ Abdominal aneurysm repair	
P☐ C☐ Irregular heart rhythm	P☐ C☐ Stroke	☐ Hysterectomy Ovaries Rem.? ☐ Y ☐ N	
P☐ C☐ Congestive heart failure	P☐ C☐ Prostate problem	☐ Gallbladder removed	
P☐ C☐ Asthma	P☐ C☐ Breast problem	☐ Appendix removed	
P☐ C☐ Emphysema or chronic bronchitis	P☐ C☐ Urinary tract infections P☐ C☐ Arthritis	☐ Intestinal Surgery	
P☐ C☐ Gastroesophageal reflux disease	P☐ C☐ Thyroid problem P☐ C☐ Bleeding disorder	☐ Joint replacement ☐ Hip ☐ Right ☐ Left	
P☐ C☐ Pneumonia	P☐ C☐ Addiction Issues	☐ Knee ☐ Right ☐ Left	
P☐ C☐ Osteoporosis/Osteopenia	P☐ C☐ Depression	☐ Spine Surgery ☐ Neck ☐ Back	
P☐ C☐ Kidney Disease, Type:	P☐ C☐ Anxiety	☐ Breast cancer surgery	
P☐ C☐ Liver Disease, Type:	P☐ C☐ Mental Illness	☐ Prostate cancer surgery	
P☐ C☐ Bowel/digestive problem	☐ Other:	☐ Hernia	
P☐ C☐ Cancer, Type:		☐ Other: ____________________	

Social History:
Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Life Partner
Live here year round? ☐ Yes ☐ No If no, Part time location: ______________________________
Occupation: **Concerns**: ☐ Stress ☐ Hazardous substances ☐ Heavy lifting
Tobacco use: ☐ Never ☐ Quit (when)__________ ☐ Current smoker: Packs/day, how many years__________________
Alcohol use: ☐ No ☐ Yes If yes how many drinks/how often______________
Caffeine use: ☐ No ☐ Yes If yes, ☐ Coffee ☐ Soda ☐ Tea how many drinks/how often______________
Illicit Drug use (including marijuana, cocaine, steroids): ☐ Never ☐ Past ☐ Current Describe:____

Family History

Relationship	Living Y/N	Age	Major Medical Problems and/or Cause of Death
Father			
Mother			
Siblings			
Children			

Specifically, have any of your relatives had the following conditions:

Condition	Relative	Condition	Relative
☐ Mental illness		☐ Chemical dependency	
☐ Diabetes		☐ Stroke	
☐ Thyroid Disease		☐ Arthritis	
☐ Pituitary Disease		☐ Dementia	
☐ Chrohn's/Colitis		☐ Hypertension	
☐ Cancer, Type: ____________________		☐ Other:	

Are there any religious or cultural factors that you would like us to take into account when planning your healthcare?

Hospital Admissions (excluding pregnancies):

Date	Hospital	Reason for admission

Allergies:

Please list any allergies to medications or foods

Name	Symptom/Reaction

Medications:

Please list any medications that you take including over the counter medications, herbs, and supplements.

Name	Dose	Freq.	Name	Dose	Freq.

Pharmacy: ___________________________________ **Phone**: ____________________ **Store #**: _____________________

Location Description: ____

Specialty Providers:

In order that we can best coordinate your care, please list any medical providers you see outside of this practice

Primary Care Name: ______________________________ Phone: ________________ Last Seen:________	**Cardiologist** Name: ______________________________ Phone: ________________ Last Seen: ________
Oncologist Name: ______________________________ Phone: ________________ Last Seen:________	**Allergist** Name: ______________________________ Phone: ________________ Last Seen: ________
Urologist Name: ______________________________ Phone: ________________ Last Seen:________	**Gynecologist** Name: ______________________________ Phone: ________________ Last Seen: ________
Gastroenterologist Name: ______________________________ Phone: ________________ Last Seen:________	**Pulmonologist** Name: ______________________________ Phone: ________________ Last Seen: ________
Podiatrist Name: ______________________________ Phone: ________________ Last Seen:________	**Other:** ________________ Name: ______________________________ Phone: ________________ Last Seen: ________

Patient/Guardian Signature:____ Date:________________