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.

_____
_____
_____

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) _____

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

Current Medications ☐ None

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

Medication_____Dose_____Frequency_____
Medication_____Dose_____Frequency_____
Medication_____Dose_____Frequency_____
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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 Use** If yes, packs/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

□	□	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**