

ORTHOPEDIC ASSOCIATES OF NAPERVILLE

HISTORY SURVEY

This questionnaire is given to aid the doctor in having a more comprehensive insight into your medical past and to aid in your future care. Please answer as requested to the best of your knowledge and recollection.

PATIENT NAME _____ DATE _____

List any physicians presently taking care of you:

<u>Practice Type</u>	<u>Physician Name</u>
Primary Care Physician	
_____	_____
_____	_____

ALLERGIES:

Do you have any allergies to medications? _____ Yes _____ No
Allergy To: Reaction Since When Treatment for reaction

MEDICATIONS:

Do you take medication prescribed by a physician? _____ Yes _____ No
Medication Dosage How Often Since when

Do you take over the counter or herbal medication on a regular basis? _____ Yes _____ No
Medication Dosage How Often Since when

PAST MEDICAL HISTORY:

Please check any below that you have been diagnosed with and write approximately how long:

____ Heart Disease _____	____ High Blood Pressure _____
____ Kidney Disease _____	____ Diabetes _____
____ Blood Clots _____	____ Cancer _____
____ Rheumatic Fever _____	____ Stoke _____
____ Ulcers _____	____ Arthritis _____
____ Other (please list) _____	

PAST SURGICAL HISTORY:

Have you had surgery? _____ Yes _____ No
Type of Surgery When Hospital Surgeon Any Complications

Did you have any problems with anesthesia? _____ Yes _____ No
What Problem? _____

PAST HOSPITALIZATIONS:

Have you been hospitalized for a non-surgical problem? Yes No

Diagnosis When Hospital Surgeon Any Complications

SOCIAL HISTORY:

Live alone or with: _____

Occupation _____

Have you ever smoked? Yes No Packs/day for years Quit when

Alcoholic beverages glasses/week beers/week never drink

Drug use marijuana cocaine opiates LSD none Other

REVIEW OF SYSTEMS:

 Recent change in weight Recent change in appetite Problems with Insomnia

 New moles New rashes Skin ulcers

 Headaches Dizziness Recent change in vision

 Blurring vision Double vision Change in hearing

 Ringing in ears Sores in mouth Change in voice

 Chest pain Heart skips beats Cough

 Shortness of breath Wheezing Coughing up blood

 Abdominal pain Change in bowel habits Nausea/Vomiting

 Blood diarrhea Black, tarry stool Incontinence

 Waking up to urinate Frequent urination Pain on urination

 Swelling in joints Joint pain weakness

 Numbness Episodes of confusion Recent change in behavior

 Problem breathing at night Nervousness Depression

 Other(please list) _____

FAMILY HISTORY:

 Name Age-If Living Age at Death Cause of Death

Mother _____

Father _____

Siblings: _____

 M/F _____

 M/F _____

Children: _____

 M/F _____

 M/F _____

Do you have a family history of:

Heart Disease Yes No Relationship

Diabetes Yes No Relationship

Circulatory Problems Yes No Relationship

Kidney Disease Yes No Relationship

Cancer Yes No Relationship

Arthritis Yes No Relationship

Other hereditary illnesses in the family (please list) _____