SELF ADMINISTERED HISTORY FORM

PARKSIDE ORTHOPEDICS-UPMC

TODAY'S DATE:_____

PATIENT NAME:_____ DATE OF BIRTH:_____

CURRENT JOB:_____ WHO LIVES IN YOUR HOUSE?_____

FAMILY DOCTOR:_____

WHO REFERRED YOU TO OUR OFFICE?_____

FAMILY HISTORY	ALIVE OR DEAD	AGE	FAMILY HEALTH PROBLEMS (INCLUDING CAUSE OF DEATH)	DO YOU HAVE ANY CLOSE RELATIVES WITH:		
				Y	N	
FATHER						HIGH CHOLESTEROL
MOTHER						HEART TROUBLE
SPOUSE						CANCER(BREAST,PROSTATE,COLON,OVARIAN)
BROTHER/SISTER						DIABETES
						HIGH BLOOD PRESSURE
						MENTAL ILLNESS
						THYROID DISEASE
CHILDREN						BLEEDING TROUBLE / BLOOD CLOTS
						GLAUCOMA
						ALCOHOL/DRUG PROBLEMS
						ALZHEIMER'S

LIST ANY MEDICATIONS YOU TAKE (INCLUDE OVER THE COUNTER)

_____

_____

_____

_____

_____

OR

SEE MEDICINE LIST COPIED

LIST ANY ALLERGIES OR BAD REACTIONS:

_____

_____

_____

_____

_____

DO YOU USE TOBACCO PRODUCTS? YES OR NO

CIRCLE ALL THAT APPLY: CIGARETTES PIPE CIGARS SNUFF/CHEW

DO YOU DRINK ALCOHOL?: YES OR NO

IF SO, HOW MANY DRINKS OER WEEK?_____

FOR WOMEN ONLY:

GYNECOLOGIC AND OBSTETRIC HISTORY:

MENOPAUSE AGE:_____

OSTEOPOROSIS: YES OR NO

DECREASE IN HEIGHT: YES OR NO IF YES, NUMBER OF INCHES_____

Pregnancies:

OF BIRTHS:_____ # OF MISCARRIAGES:_____ LIVING CHILDREN:_____

Are you currently pregnant or could you be pregnant?_____

PATIENT SIGNATURE:_____ DATE:_____

PHYSCIAN SIGNATURE:_____ DATE:_____

OVER→

CHECK YES OR NO BELOW FOR ANY OF THESE ISSUES YOU HAVE HAD SIGNIFICANT PROBLEMS WITH:

PROBLEM	YES	NO	PROBLEM	YES	NO
HEADACHES			BREATHING PROBLEMS		
EYE TROUBLE			HIGH CHOLESTEROL		
HEARING PROBLEMS			HEART TROUBLE		
DENTAL/GUM PROBLEMS			LIVER DISEASE		
THYROID DISEASE			STOMACH TROUBLE		
DIABETES			KIDNEY DISEASE		
ANEMIA			TROUBLE URINATING		
CANCER			BOWEL TROUBLE		
BREAST LUMP			HEMORRHOIDS		
HIGH BLOOD PRESSURE			PHLEBITIS		
ARTHRITIS			SERIOUS INJURY		
GOUT			TUBERCULOSIS		
FAINTING/CONVULSIONS			RHEUMATIC FEVER		
ABNORMAL BLEEDING			VENEREAL DISEASE		
HIVES OR RASHES			ALCOHOL/DRUG PROBLEM		
HEPATITIS			WEIGHT LOSS		
SLEEPING DIFFICULTY			DEPRESSION		
NERVOUSNESS			STROKE		
OTHER			MRSA		

HOSPITALIZATIONS:

OPERATION/ILLNESS	YEAR	OPERATION/ILLNESS	YEAR

PATIENT SIGNATURE:_____ DATE:_____

DATE OF PERIODIC UPDATE BY PATIENT:_____ _____ _____

_____ _____ _____

PHYSICIAN SIGNATURE OF INITIAL REVIEW:_____ DATE:_____

REVIEW OF UPDATED INFO-PHYSICIAN SIGN:_____ DATE:_____

REVIEW OF UPDATED INFO-PHYSICIAN SIGN:_____ DATE:_____

REVIEW OF UPDATED INFO-PHYSICIAN SIGN:_____ DATE:_____