Beth Israel Lahey Health
New England Baptist Orthopedics

COMPREHENSIVE HEALTH HISTORY

PLEASE USE BLUE OR BLACK INK ONLY

Name:_____ Today's Date:_____

Date of Birth:_____ Age:_____ Height:_____ ft _____ in Weight:_____ lbs

Primary Doctor Name and Address:

_____

_____

Preferred Pharmacy (Address/Phone):

_____

_____

MEDICATIONS (prescribed and over the counter): ☐ ***I take no medications***

Name of Medication	Dose	Reason

ALLERGIES (i.e. medications, foods, other) ☐ ***No Allergies***

Name of Allergy	Reaction (rash, swelling, stomach upset, etc.)

METAL ALLERGIES: ☐ ***No Allergies*** ☐ Yes_____ (List Metals)

Beth Israel Lahey Health
New England Baptist Orthopedics

COMPREHENSIVE HEALTH HISTORY

Name:_____ Date of Birth:_____

MEDICAL HISTORY: Check all that apply ☐ ***None Apply***

PAST | CURRENT

- ☐ ☐ Attention-deficit/hyperactivity (ADD/ADHD)
- ☐ ☐ Addiction problem
- ☐ ☐ Alcoholism
- ☐ ☐ Allergic rhinitis
- ☐ ☐ Anemia
- ☐ ☐ Anxiety
- ☐ ☐ Arthritis
- ☐ ☐ Asthma
- ☐ ☐ Atrial fibrillation
- ☐ ☐ Bleeding disorder
- ☐ ☐ Cancer
  Type/treatment: _____
- ☐ ☐ Cerebral palsy
- ☐ ☐ Congestive heart failure (CHF)
- ☐ ☐ Cirrhosis
- ☐ ☐ Clotting disorder
- ☐ ☐ Coombs positive
- ☐ ☐ Chronic obstructive pulmonary disease (COPD / chronic bronchitis
- ☐ ☐ Deep vein thrombosis (DVT)
- ☐ ☐ Dementia
- ☐ ☐ Depression
- ☐ ☐ Diabetes: year diagnosed: _____
  Currently controlled with
  ☐ Insulin ☐ Oral medications ☐ Diet
- ☐ ☐ Diabetic neuropathy:
  ☐ Hands / ☐ Feet
- ☐ ☐ Down syndrome
- ☐ ☐ Emphysema
- ☐ ☐ Gastric reflux
- ☐ ☐ Gastroesophageal reflux disease (GERD)
- ☐ ☐ Gout
- ☐ ☐ Headache
- ☐ ☐ Heart murmur
- ☐ ☐ Heart valve problem
- ☐ ☐ Hepatitis (A, B, or C)
- ☐ ☐ Hiatal hernia
- ☐ ☐ HIV/AIDS
- ☐ ☐ Hypercholesterolemia

PAST | CURRENT

- ☐ ☐ Hypertension / high blood pressure
- ☐ ☐ Inflammatory bowel disease
- ☐ ☐ Jaundice
- ☐ ☐ Kidney disease
- ☐ ☐ Kidney stones
- ☐ ☐ Kyphosis
- ☐ ☐ Meningitis
- ☐ ☐ Migraines
- ☐ ☐ MRSA infection / colonization
- ☐ ☐ Myocardial infarction (heart attack)
- ☐ ☐ Nerve / muscle disease
- ☐ ☐ Neurofibromatosis
- ☐ ☐ Neuropathy - peripheral:
  ☐ Hands / ☐ Feet
- ☐ ☐ Obesity
- ☐ ☐ Osteoarthritis
- ☐ ☐ Osteomyelitis
- ☐ ☐ Osteoporosis (brittle bones)
- ☐ ☐ Paralysis
- ☐ ☐ Pneumonia
- ☐ ☐ Pulmonary embolism
- ☐ ☐ Peripheral vascular disease (PVD)
- ☐ ☐ Raynaud's phenomenon
- ☐ ☐ Rheumatoid arthritis
- ☐ ☐ Scoliosis (spine / back curvature)
- ☐ ☐ Seizures
- ☐ ☐ Sickle cell anemia / trait
- ☐ ☐ Sleep apnea / obstructive
- ☐ ☐ Spina Bifida
- ☐ ☐ Stroke
- ☐ ☐ Substance abuse
- ☐ ☐ Thyroid disease
- ☐ ☐ Tuberculosis
- ☐ ☐ Ulcers (GI)
- ☐ ☐ Urinary tract infection (UTI / bladder infection)
- ☐ ☐ Varicella (chicken pox)
- ☐ ☐ Weight loss

☐ Other: _____

_____

COMPREHENSIVE HEALTH HISTORY

Name:_____ Date of Birth:_____

PAST SURGICAL HISTORY: ☐ ***No Prior Surgery***

Operation	Date	Surgeon/Hospital

Have you ever had general anesthesia? ☐ No ☐ Yes
If YES, have you had any problems related to this? ☐ No ☐ Yes
Please explain any problems related to general anesthesia: _____

_____

SOCIAL HISTORY:

Work status:

☐ Working ☐ Homemaker ☐ Unemployed ☐ Disabled ☐ On leave ☐ Retired ☐ Student

Occupation (If retired, former occupation)_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Children ☐ No ☐ Yes, How Many?_____

Do you live alone?_____ If no, who lives with you?_____

Are you currently smoking?_____ If yes, how many packs a day?_____ For how many years?_

Have you quit smoking? If so, when did you quit?_____ How many years did you smoke?_____

How many packs a day did you previously smoke?_____Other forms of tobacco?_____

Alcohol Use ☐ Never ☐ Rare ☐ Social ☐ Frequently (more than twice a week)
☐ Alcoholic ☐ Recovering Alcoholic

Illegal Drug Use ☐ Never ☐ In the past ☐ Currently Types of Drugs_____

COMPREHENSIVE HEALTH HISTORY

Name:_____ Date of Birth:_____

FAMILY HISTORY: Check all that apply ☐ ***None apply***

	Father	Mother	Brother	Sister	Son	Daughter	Other (Grandparent, etc) (Specify)_____
Heart Disease							
Scoliosis							
Kyphosis							
Spondylolisthesis							
Arthritis							
Seizure							
Bleeding Problems							
High Blood Pressure							
Stroke							
Gout							
Alcoholism							
Cancer							
Blood Clots							
Kidney Problems							
Diabetes							
Lung Problems							
Mental Illness							
Other _____							

Other Family History:_____

_____

_____

COMPREHENSIVE HEALTH HISTORY

Name:_____ Date of Birth:_____

REVIEW OF SYSTEMS: (in the past 30 days have you experienced any of the following?)

☐ Fever	☐ Sleep apnea (snoring)	☐ Nausea
☐ Chills	☐ Hoarseness	☐ Vomiting
☐ Weight loss	☐ Cough	☐ Diarrhea
☐ Weight gain	☐ Trouble swallowing	☐ Constipation
☐ Vision changes ☐ ***Chest pain***		☐ Hemorrhoids
☐ Glasses/Contacts	☐ ***Palpitations***	☐ Stomach pain
☐ Hearing loss	☐ Swollen ankles	☐ Urinary difficulty
☐ Dizziness	☐ ***Shortness of breath***	☐ Anxiety
☐ Ear pain	☐ Seasonal allergies	☐ Hyperactivity
☐ Nosebleeds	☐ Skin rashes	☐ Memory loss
☐ Toothache	☐ Swollen glands	☐ Blackouts
☐ Gum problems	☐ Poor appetite	☐ Headache

☐ ***I have not experienced any of the above symptoms in the last 30 days***

☐ Other:_____

_____

FOR OFFICE USE ONLY

I have read and confirmed the above information with the patient/family:

Physician Signature:_____ Date: