Orozco Orthopaedics Health History Form

Name: ________________________________ Preferred Name: __________________ DOB: ______/______/______

Primary Care Doctor: ___________________________________ Cardiologist: _________________________________

Other Physician (ex. Pulm.) :______________________________Other Physician:_______________________________

Name of person/ physician making referral: ____

Occupation/Job Current or Previous: ____ Retired: ☐ Yes ☐ NO

Reason for visit: ____

Is this a worker's compensation case ☐ Yes ☐ No Personal Injury/slip and fall: ☐ Yes ☐ No Auto ☐ Yes ☐ No

Approximate Date symptoms started: _____________ Have you been treated for this condition before: ☐ Yes ☐ No

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If so when, by who, and what have you tried: ☐ injections ☐ exercises/ therapy ☐ weight loss ☐ surgery

Please briefly describe:

MEDICAL/ SURGICAL HISTORY

Allergies: ☐ NO KNOWN DRUG ALLERGIES ☐ LATEX OTHER: ____

Height: ___________ Weight:____________ Average Pain Level: 0 no pain 10 worst pain ______/ 10

Past Medical History		Past Surgical History with Dates/ Year
1.________________________________	6. ___________________________	1. _____________________________
2. _______________________________	7. ____________________________	2. _____________________________
3.________________________________	8. ____________________________	3. ______________________________
4.________________________________	9. ____________________________	4. ______________________________
5.________________________________	10. ___________________________	5. ______________________________

Check the box if you do not have any medical conditions ☐

Vaccination History

Influenza _____/_____/______ Pneumonia _____/_____/______, _____/_____/______ Tdap: _____/_____/______

COVID: _____/_____/______, _____/_____/______, _____/_____/______, Shingles:_____/_____/______

Family Medical History

Mother: _________________________ Father: _______________________ Siblings: ____________________________

Medications (including over the counter vitamins, supplements, and pain relievers)

Medication Name	Dose	Frequency		Medication Name	Dose	Frequency
1. ______				8. ______		
2. ______				9. ______		
3. ______				10. ______		
4. ______				11. ______		
5. ______				12. ______		
6. ______				13. ______		
7. ______				14. ______		

Social History

Marital Status (circle): M S D W Do you smoke: ☐ Yes ☐ No Former smoke ☐ Yes ☐ No Date quit: ___/____/___

Alcohol use: ☐ Yes ☐ No How often: _______________________ Beverage of choice: ___________________________

Other: ____

Living Arrangements

Do you live alone ☐ Yes ☐ No If you live alone do you have help/ support if needed: ☐ Yes ☐ No

Does your home have stairs ☐ Yes ☐ No How many? _______ Do you have reliable transportation: ☐ Yes ☐ No

Do you require assistive devices: ☐ Yes ☐ No If yes, ☐ Cane ☐ Walker ☐ Rollator ☐ Wheelchair ☐ Scooter

History of Falls ☐ Yes ☐ No Do you wear glasses ☐ Yes ☐ No Do you wear hearing aids ☐ Yes ☐ No

Other important details: ____

I verify that the above information is correct to my knowledge.

Patient Signature____ Date: _______________