

# CAROLINA BONE & JOINT, PA

## PATIENT PAST HISTORY

DATE: \_\_\_\_\_

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ SEX: M  F  RACE: \_\_\_\_\_

### PAST MEDICAL HISTORY (Check if "yes")

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Psoriasis         | <input type="checkbox"/> High blood pressure          | <input type="checkbox"/> Anemia                    |
| <input type="checkbox"/> Iritis/scleritis  | <input type="checkbox"/> Heart disease                | <input type="checkbox"/> Blood transfusion         |
| <input type="checkbox"/> Sinusitis         | <input type="checkbox"/> Stomach ulcer                | <input type="checkbox"/> Blood clots               |
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Duodenal ulcer               | <input type="checkbox"/> Raynaud's phenomenon      |
| <input type="checkbox"/> Emphysema         | <input type="checkbox"/> Crohn's disease              | <input type="checkbox"/> Migraine headache         |
| <input type="checkbox"/> Pneumonia         | <input type="checkbox"/> Ulcerative colitis           | <input type="checkbox"/> Epilepsy/seizure disorder |
| <input type="checkbox"/> Thyroid disease   | <input type="checkbox"/> Irritable bowel syndrome     | <input type="checkbox"/> Stroke/TIA                |
| <input type="checkbox"/> Diabetes mellitus | <input type="checkbox"/> Hepatitis/liver disease      | <input type="checkbox"/> Muscle disease            |
| <input type="checkbox"/> Osteoporosis      | <input type="checkbox"/> Kidney disease               | <input type="checkbox"/> Nerve disease             |
| <input type="checkbox"/> Broken bone(s)    | <input type="checkbox"/> Kidney stone                 | <input type="checkbox"/> Psychiatric disease       |
| <input type="checkbox"/> Cancer            | <input type="checkbox"/> Sexually-transmitted disease | <input type="checkbox"/> Drug or alcohol abuse     |

Rheumatological diseases you have or had: \_\_\_\_\_  
 Other conditions you have or had: \_\_\_\_\_

### HOSPITALIZATIONS/OPERATIONS

	Describe the reason for hospitalization or operation IF N/A PLEASE INDICATE	Year
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____

### CURRENT MEDICATIONS (names only)

- |          |          |           |
|----------|----------|-----------|
| 1. _____ | 5. _____ | 9. _____  |
| 2. _____ | 6. _____ | 10. _____ |
| 3. _____ | 7. _____ | 11. _____ |
| 4. _____ | 8. _____ | 12. _____ |

### DRUG ALLERGIES \_\_\_\_\_

### FAMILY HISTORY

	Alive/Deceased	Age	Medical diseases and/or conditions
Mother	_____	_____	_____
Father	_____	_____	_____
Sister	_____	_____	_____
Sister	_____	_____	_____
Brother	_____	_____	_____
Brother	_____	_____	_____

### SOCIAL HISTORY

Highest level of education: \_\_\_\_\_ Occupation: \_\_\_\_\_ Disabled? No  Yes   
 Marital status (check one): never married  married  divorced  widow (er)  Number of children: \_\_\_\_\_  
 Do you use any tobacco product? No  Yes  Do you drink alcohol? No  Yes   
 Religion: \_\_\_\_\_ Hobbies you enjoy: \_\_\_\_\_  
 How many people live in your home? \_\_\_\_\_ Who does most of your housework? \_\_\_\_\_  
 I live in a ... (check one) House  Condo  Apartment  Do you have stairs to climb at home? No  Yes   
 What sports do you play? \_\_\_\_\_