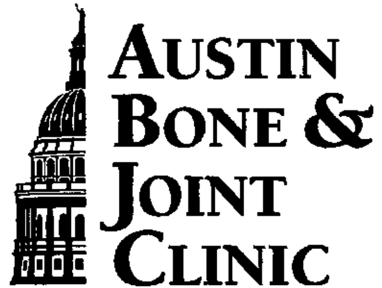
AUSTIN BONE & JOINT CLINIC

HEALTH QUESTIONNAIRE



Name:______________________________

Date: ______________________________

Social History

Do you drink?

O No O socially O daily

Do you smoke? If so, how many packs per day (ppd)?

O No O less the 1 ppd O 1 ppd O 2 ppd O 3 ppd

Have you ever used illegal drugs?

O Yes O No

Do you exercise regularly?

O never O rarely O sometimes O daily

What is your marital status?

O Single O Married O Widowed O Separated

Which sports do you play? (may choose multiple)

O football O soccer O basketball O track O jogging
O baseball O volleyball O martial arts O yoga
O biking O swimming O golf

What is your current living arrangement? (may choose multiple)

O Home O Nursing Home O Alone O With Spouse
O With Children O Other

Is there a lawsuit involved with this injury?

O Yes O No

Were you injured at work?

O Yes O No

Are you currently employed? (may choose multiple)

O Yes O Retired O Permanently disabled
O In between jobs O No

Past Medical History

Asthma	O Yes	O No	**Hypertension**	O Yes	O No
High cholesterol	O Yes	O No	**COPD**	O Yes	O No
Hypothyroidism	O Yes	O No	**Anxiety disorder**	O Yes	O No
Osteoarthritis	O Yes	O No	**Acid reflux**	O Yes	O No
Gout	O Yes	O No	**Depression**	O Yes	O No

Name:______________________________

Past Medical History

Condition	Yes	No	Condition	Yes	No
Urinary incontinence	O Yes	O No	**Seizures**	O Yes	O No
Blood clots	O Yes	O No	**Pulmonary emobolism**	O Yes	O No
Diabetes, type I	O Yes	O No	**Diabetes, type II**	O Yes	O No
Cancer	O Yes	O No	**Osteoporosis**	O Yes	O No
Recurrent UTI's	O Yes	O No	**Rheumatoid Arthritis**	O Yes	O No
Fibromyalgia	O Yes	O No	**Pacemaker**	O Yes	O No
Stroke	O Yes	O No	**GI bleed**	O Yes	O No
Heart attack	O Yes	O No	**Hepatitis**	O Yes	O No
Congestive heart failure	O Yes	O No	**Kidney disease**	O Yes	O No
Other heart disease	O Yes	O No	**Alcohol abuse**	O Yes	O No
MRSA	O Yes	O No	**HIV positive**	O Yes	O No
Liver disease	O Yes	O No	**Drug addiction**	O Yes	O No
Peripheral neuropathy	O Yes	O No	**Sleep apnea**	O Yes	O No

Family History

O Hypertension O Heart Attack O Stroke O Cancer O Diabetes
O Anesthesia O Arthritis

Review of Systems

Symptom	Yes	No	Symptom	Yes	No
Loss of balance	O Yes	O No	**Weight gain**	O Yes	O No
Loss of appetite	O Yes	O No	**Fever**	O Yes	O No
Weakness	O Yes	O No	**Night sweats**	O Yes	O No
Weight loss	O Yes	O No	**Fatigue**	O Yes	O No
Headache	O Yes	O No	**Dizziness**	O Yes	O No
Chest pain	O Yes	O No	**Palpitations**	O Yes	O No
Leg swelling	O Yes	O No	**Shortness of breath**	O Yes	O No
Blood in stool	O Yes	O No	**Diarrhea**	O Yes	O No
Vomiting	O Yes	O No	**Constipation**	O Yes	O No
Nausea	O Yes	O No	**Tingling numbness**	O Yes	O No
Cough	O Yes	O No	**Panic attacks**	O Yes	O No
High stress level	O Yes	O No	**Painful urination**	O Yes	O No
Blood in Urine	O Yes	O No			

Austin Bone & Joint Clinic Medical Information

Patient Name: ______________________________ Ht.: ________ Wt.: ________

LIST MEDICINES YOU ARE TAKING WITH THE DOSAGE:

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

ARE YOU ALLERGIC TO: (Circle all that apply)
☐ NO KNOWN DRUG ALLERGIES

Novocaine Xylocaine Cortisone Aspirin Codeine Hydrocodone
Vicodin Shellfish Adhesive Tape

LIST ANY OTHER MEDICATIONS TO WHICH YOU ARE ALLERGIC:

1.	3.
2.	4.

PRIOR SURGERY: Please list and date
☐ NO PREVIOUS SURGERY

1.	4.
2.	5.
3.	6.

Anesthesia History	Yes	No	Continued	Yes	No
Nausea			Malignant Hyperthermia		
Vomiting			Other		

Primary Care Physician: ______________________ Other Specialist: ________________

Signature: ______________________________ Date: ________________