PINEHURST HIP & KNEE CENTER, P.A.

PATIENT'S PAST MEDICAL HISTORY **PATIENT'S NAME:** ____________________

Brief Description of the Problem:		If in pain, please rate on scale from 0 = no pain, 10 = worst pain	
Date Problem Started/Date of Injury:		Where did this happen? ☐ Automobile ☐ Home ☐ Work ☐ Other	
Occupation/School:	Are you off work/out of school? ☐ Yes ☐ No	Last Day of Work:	Age:
Referred By:	Family Physician:	Height: feet inches	Weight:

Allergies: ☐ None ☐ Contrast Dye ☐ Latex **Drug Allergies**:

☐ **Current Medications**, including herbs and/or supplements: ☐ I do not take prescription medicines.
****Please list all medications in the space provided below or attach a medication list to this form****

List All Previous Surgeries below. Indicate the type of surgery and year. If you run out of space, write on back. ☐ I have never had surgery.

Is there a chance you are pregnant? ☐ Yes ☐ No

☐ Right ☐ Left **Dominant Hand**

Assistive Devices:
☐ Yes ☐ No Are you able to walk?
☐ Yes ☐ No Do you use a cane or walker?

General Health

☐ Yes ☐ No Antibiotic Resistance Illnesses (MRSA/VRE)
☐ Yes ☐ No Cancer
☐ Yes ☐ No Fever

Eyes

☐ Yes ☐ No Cataracts
☐ Yes ☐ No Glasses
☐ Yes ☐ No Glaucoma

Ears, Nose, Throat, and Mouth

☐ Yes ☐ No Deafness
☐ Yes ☐ No Hoarseness
☐ Yes ☐ No Other: ____________________

Respiratory

☐ Yes ☐ No Airway Abnormalities
☐ Yes ☐ No Asthma, Wheezing, Bronchitis, Emphysema, TB, or other lung problems, COPD
☐ Yes ☐ No Sleep Apnea

Cardiovascular

☐ Yes ☐ No Are you taking Coumadin or other blood thinner?
☐ Yes ☐ No Heart Attack Date:__________
☐ Yes ☐ No Heart Disease/Heart Failure
☐ Yes ☐ No High Blood Pressure
☐ Yes ☐ No High Cholesterol
☐ Yes ☐ No Irregular Heartbeat, Palpitations
☐ Yes ☐ No Pacemaker, Defibrillator
☐ Yes ☐ No Peripheral Vascular Disease
☐ Yes ☐ No Rheumatic Fever, Heart Murmur

Gastrointestinal

☐ Yes ☐ No Frequent Heartburn, Acid Reflux, Hiatal Hernia
☐ Yes ☐ No GI Bleed (gastrointestinal)
☐ Yes ☐ No Hepatitis, Cirrhosis, Liver Disease
☐ Yes ☐ No Ulcers

Bladder and Kidney

☐ Yes ☐ No Incontinence
☐ Yes ☐ No Kidney Failure, Dialysis, Urinary Problems, Kidney Disease
☐ Yes ☐ No Males: Prostate Problems

Bones, Muscles, and Joints

☐ Yes ☐ No Arthritis, Stiffness
☐ Yes ☐ No Fibromyalgia
☐ Yes ☐ No Fractures
☐ Yes ☐ No Osteoporosis
☐ Yes ☐ No Pain
☐ Yes ☐ No Sprains/Swelling
☐ Yes ☐ No Total Hip Replacement R L
☐ Yes ☐ No Total Knee Replacement R L
☐ Yes ☐ No Knee Arthroscopy R L
☐ Yes ☐ No Hip Arthroscopy R L

Neurological/ Psychological

☐ Yes ☐ No Balance, Dizziness, or Falls
☐ Yes ☐ No Brain Injury
☐ Yes ☐ No Convulsions, Seizures, Fainting
☐ Yes ☐ No Depression
☐ Yes ☐ No Memory Problems
☐ Yes ☐ No Numbness/Tingling Arms/Legs
☐ Yes ☐ No Speech or Swallowing Problems
☐ Yes ☐ No Stroke
☐ Yes ☐ No Weakness
☐ Yes ☐ No Restless Leg Syndrome

Blood Disorders

☐ Yes ☐ No Anemia or Sickle Cell Illness
☐ Yes ☐ No Blood Clots
☐ Yes ☐ No HIV Positive/AIDS
☐ Yes ☐ No Lymph Node Pain/Enlargement
☐ Yes ☐ No Prolonged Bleeding After Minor Cut or Bruise Easily
☐ Yes ☐ No Varicose Veins

Allergic/Immunologic

☐ Yes ☐ No Eczema
☐ Yes ☐ No Rheumatoid Arthritis
☐ Yes ☐ No Unusual Reaction to Anesthesia By You or By a Family Member

Endocrine

☐ Yes ☐ No Diabetes, Onset Age:_________
☐ Yes ☐ No Growth Problems
☐ Yes ☐ No Thyroid Problems

☐ **Yes** ☐ **No Other Medical Problems:**
____
____
____

Social History: Do you smoke?
☐ Yes ☐ No ☐ Former
Pack(s)/Day ______ Number of Years ______

☐ Yes ☐ No Do you average 3 or more alcoholic beverages per day?
☐ Yes ☐ No Do you use recreational drugs?

☐ Yes ☐ No Do you live alone?
☐ Yes ☐ No Do you have children?
Children's Names:

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Family History: ☐ Yes ☐ No Is your mother living? ☐ Yes ☐ No Is your father Living?		_____ How may brothers do you have? ☐ Yes ☐ No Are all brothers alive?		_____ How many sisters do you have? ☐ Yes ☐ No Are all sisters alive?
Other:				
Please indicate which of your blood relatives (M=Mother, F=Father, S=Sister, B=Brother) have a history of the following health problems:	___ Alcoholism ___ Anemia ___ Arthritis ___ Asthma	___ Bleeds easily ___ Cancer ___ Diabetes ___ Epilepsy	___ Glaucoma ___ Heart Disease ___ High Blood Pressure ___ High Cholesterol	___ Migraine ___ Stroke ___ Thyroid Problems ☐ None of these problems in my family

Patient/Representative Signature:____ **Date:**