



PENINSULA ORTHOPAEDIC ASSOCIATES
PATIENT HISTORY SHEET

Name:	
POA ID #:	Dr:
Date:	Appt:
DOB:	Age:
PCP:	

Review of Systems: Do you have? (Answer yes or no for each)

Fever, night sweats	<input type="checkbox"/> Yes <input type="checkbox"/> No	Burning with Urination	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty sleeping	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eye Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequency of urination	<input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Thirst	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sore Throat	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty Urinating	<input type="checkbox"/> Yes <input type="checkbox"/> No	Intolerance to heat/cold	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Muscle Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Easy bleeding or bruising	<input type="checkbox"/> Yes <input type="checkbox"/> No
Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin rashes or sores	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Abdominal Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches or dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Heart Burn/Reflux	<input type="checkbox"/> Yes <input type="checkbox"/> No	Depressed	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Past Medical History: Do you have, have you had, or do you take medications for?

Diabetes (if yes do you use an insulin pump? Y N)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease/Nephrotic syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No	Paroxysmal nocturnal hemoglobinuria	<input type="checkbox"/> Yes <input type="checkbox"/> No
High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Inflammatory bowel disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hypercholesterolemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer (If yes list below?)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Thinners	<input type="checkbox"/> Yes <input type="checkbox"/> No	MRSA infection	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sleep Apnea (if yes, do you use a C-Pap? Y N)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lower extremity partial or total paralysis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Leukemia, lymphoma, multiple myeloma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Varicose veins	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No
Peptic Ulcer/GERD	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke/Aneurysm	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thrombophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cardiac Disease/heart attack	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood Clots	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hypo/hyperthyroidism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pregnant within 3 months	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pulmonary embolism	<input type="checkbox"/> Yes <input type="checkbox"/> No

Other medical problems not listed above:

Past Surgical History:

Have you ever had Malignant hyperthermia at the time of surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Procedure	Date Anesthesia Problems?
	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No

Family History: Do any immediate family members have or have had:

Blood Clots or pulmonary embolism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sudden death	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anesthesia Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No	Malignant hyperthermia	<input type="checkbox"/> Yes <input type="checkbox"/> No

Social History:

Do you smoke cigarettes, cigars or a pipe?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, Amount/ frequency years:
Do you consume alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, #drinks per day/week/mo :
What is your occupation?		
What is your primary sport, hobby or interest?		
What is your email address?		

For Surgery H & P only: Who will be with you on the night of surgery? _____

Patient Signature:	Provider Signature:
Date:	Date:

