

DES MOINES ORTHOPAEDIC SURGEONS, P.C.

6001 Westown Parkway
West Des Moines, Iowa 50266

311 South Clark Street, Suite 285
Carroll, IA 51401

1301 Penn Avenue, Suite 213
Des Moines, Iowa 50316

DATE: _____

GENERAL HEALTH HISTORY

NAME: _____ SEX: M F AGE: _____

PERSONAL PHYSICIAN: _____ LAST CHECK UP: _____

HEIGHT: _____ WEIGHT: _____

ILLNESS: Have you ever had:

	Yes	No	Required Treatment	Required Hospitalization	Comments
Sleep Apnea	___	___	___	___	
High Blood Pressure	___	___	___	___	
Heart Disease	___	___	___	___	
Diabetes	___	___	___	___	
Asthma	___	___	___	___	
Pneumonia	___	___	___	___	
Blood Clots	___	___	___	___	
Ulcer	___	___	___	___	
Kidney Disease	___	___	___	___	
Anemia	___	___	___	___	
Seizures	___	___	___	___	
Liver Disease/Hepatitis	___	___	___	___	
Fibromyalgia	___	___	___	___	

PAST SURGERIES:

Yes	No		When:	Comments
___	___	Appendectomy	_____	
___	___	Gallbladder	_____	
___	___	Hernia Repair	_____	
___	___	Hysterectomy	_____	
___	___	Coronary (Heart) Catheterization	_____	
___	___	Coronary Artery Bypass	_____	
___	___	Pacemaker	_____	
___	___	Lower Extremity Bypass	_____	
___	___	Prostate	_____	
___	___	Joint Surgery	_____	Type: _____
___	___	Back Surgery	_____	
___	___	Wound Infections	_____	
___	___	Anesthesia Complications	_____	
___	___	Other _____	_____	

CURRENT MEDICATIONS:

	Dose:	Times Each Day:
1.		
2.		
3.		
4.		
5.		
6.		

ALLERGIES TO MEDICATIONS:

	Yes	No		Yes	No	
1.	___	___	Penicillin	___	___	
2.	___	___	Sulfa	___	___	
3.	___	___	Demerol	___	___	
4.	___	___	Morphine	___	___	
5.	___	___	Codeine	___	___	
6.	___	___	Novocain/Local anesthetics	___	___	
7.	___	___	Iodine	___	___	
8.	___	___	Latex	___	___	
9.	___	___	Other	___	___	

Please describe any reaction to drug. _____

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SOCIAL HISTORY:

Marital Status: ___ Single ___ Married ___ Divorced ___ Separated ___ Widow(er)

Occupation: _____

Living: I live in a **Home:** _____ **Apt.** _____ **Retirement Complex** _____ **Other** _____
 I live **With Spouse:** _____ **Alone** _____ **Other** _____

Habits:

Yes	No		
___	___	Smoke	Packs per day _____ How many years _____
___	___	Alcohol	Average consumption per week _____
___	___	Coffee	Cups per day _____

<u>FAMILY HISTORY</u>	<u>Alive</u>	<u>Deceased</u>	<u>Age</u>	<u>Health status or cause of death</u>
Grandmother (mom's)	A	D	_____	_____
Grandfather (mom's)	A	D	_____	_____
Grandmother (dad's)	A	D	_____	_____
Grandfather (dad's)	A	D	_____	_____
Father	A	D	_____	_____
Mother	A	D	_____	_____
Sister/Brother	A	D	_____	_____
Sister/Brother	A	D	_____	_____

REVIEW OF SYSTEMS:

	<u>Yes</u>	<u>No</u>	<u>(If Yes, please circle – Current Symptoms Only)</u>
1.	___	___	Fevers, chills, sweats.
2.	___	___	Loss of appetite, loss of weight.
3.	___	___	Chest pain, shortness of breath, rapid or irregular heart beat, swollen ankles, fainting spells.
4.	___	___	Persistent cough, cough up blood, difficulty breathing, emphysema, pneumonia, TB.
5.	___	___	Heart burn, ulcer, vomited blood, jaundice, hepatitis.
6.	___	___	Bladder infection, kidney stones, blood in urine.
7.	___	___	Headache, dizzy spells, seizures, stroke, head injury.
8.	___	___	Rheumatoid arthritis, gout, lupus.
9.	___	___	Depression, nervous breakdown.
10.	___	___	Thyroid trouble, elevated blood sugar.
11.	___	___	Anemia, blood clots, bleeding problems, phlebitis.
12.	___	___	Cancer: (Type) _____

Your orthopaedic problem (Briefly Describe current problem and location, duration of symptoms, history of trauma and previous treatments tried):

[Do Not Write Below Line – For Office Use Only]

REVIEWED AND UPDATED	PHYSICIAN	DATE
_____	_____	_____
_____	_____	_____