OSBORNE ORTHOPEDIC GROUP HEALTH HISTORY FORM

Patient Name: ______________________________ DOB: ___/___/___

Reason for your visit today: ______________________________

Circle One (*auto accident* *work accident* *other accident* *no accident*) Accident Date: ___/___/___

Where were you and what were you doing when the accident occurred: ______________________________

____

Previous surgeries/hospitalizations (include year of occurrence): ______________________________

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____

Are you (circle one) (*retired* *student* *disabled* *employed*) Occupation: ______________________________

Do you live alone (Y N)? Chemical dependency (incl. marijuana, alcohol) (Y N) Substance:__________

Tobacco use (Y N); How much daily (i.e. 1 pack) __________; for how long (i.e. 1988-1992)__________

Alcohol consumption (circle one): daily 1-2 x/week 1-2 x/ month 1-2x/year never

Please indicate if you or a blood relative **BR** (mother, father, sister, etc) have had the following:

	Y	N	BR		Y	N	BR
AIDS/HIV +				Heart Condition			
Allergies to Anesthetics				Heart Attack			
Anemia, any type				Hepatitis, any type			
Arthritis, rheumatoid				High Blood Pressure			
Arthritis, osteoarthritic				Kidney Problems			
Asthma				Liver Disease			
Balance Problems				Low Blood Pressure			
Bleeding Disorder				Neuropathy			
Cancer				Psychiatric Care			
Chemical Dependency				Respiratory Disease			
Chronic Diarrhea				Rheumatic Fever			
Circulatory Problems				Shortness of Breath			
Diabetes				Sinus Problems			
Epilepsy				Special Diet			
Fainting				Stroke			
Gout				Tubercluosis			
Headaches				Stomach Ulcer			
Heart disease				Weight Loss/Gain, unexplained			

ALLERGIES: ______________________________

MEDICATIONS (use back for more room): ______________________________

Signature: ______________________________ Date: ___/___/___