



A Division of Ortho Kentucky, PLLC

HEALTH & HISTORY QUESTIONNAIRE

Please answer all questions completely. Information is confidential.

Date _____

Your Name _____ Age _____

Chief Complaint

Why are you seeing the doctor today? _____

Present Illness

Who referred you? _____

Who is your current medical doctor? _____

When did this first start? _____

How did this start? Accident Gradual Infection

What has your previous treatment been? _____

Past Medical History

Current Medications _____

Previous Surgery _____

Allergies _____

Are you diabetic? _____ If yes, your average sugar? _____

Cardiologist _____

Neurologist _____

Pain Management Dr. _____

Rheumatologist _____

Pulmonary Dr. _____

Other Orthopaedic Dr. _____

Family History

Member	Alive	Deceased	Age	Health Issues
Father				
Mother				
Sister/Brother				
Sister/Brother				
Other				

PLEASE COMPLETE THE REVERSE SIDE AND SIGN

Social History

Where do you live? Home With family In facility outside of home

Do you smoke? _____ How Much? _____

When did you quit? _____

Do you use alcohol? _____ How Much? _____

When did you quit? _____

What is your employment? _____

What is your usual exercise level? _____

Review of Systems (circle and describe any problems)

Eyes	
Ears, nose, & throat	
Lungs & breathing	
Heart problems	
Liver problems	
Digestion	
Kidney problems	
Bladder problems	
High blood pressure	
Balance problems	
Blackout/fainting	
Seizures	
Cancer	
Skin problems	
Arthritis	

*****FOR OFFICE USE ONLY*****

Date _____ Ht. _____ Wt. _____ B.P. _____ / _____ Pulse _____

