Orthopaedic Surgery & Sports Medicine ♦ General Surgery
New Patient Health History Form

Patient name: ______________________________ Age: _____ Date of birth: ________________

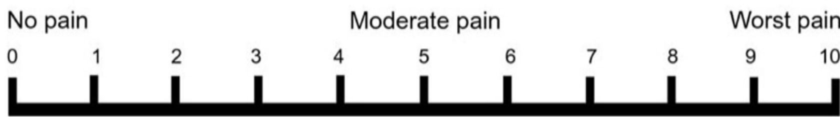
Reason for visit:______________________________ Onset of symptoms: ______________________

Family doctor: ______________________________

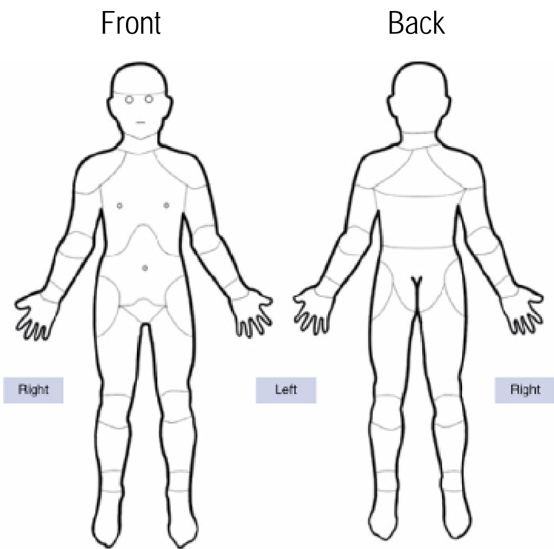
Specialists (heart doctor, kidney doctor, etc.): ______________________________

Preferred pharmacy: ______________________________

SEVERITY OF YOUR PAIN CURRENTLY: Place an "X" on the pain scale to indicate your level of pain. Place an "X" on the body diagrams to indicate where your pain is located.



Front Back



MEDICATIONS: If you are NOT an established WMed Health patient, please list your current medications:

1. ______________________ 6. ______________________
2. ______________________ 7. ______________________
3. ______________________ 8. ______________________
4. ______________________ 9. ______________________
5. ______________________ 10. ______________________

ALLERGIES: (Reaction)______________________________

Revised: 10/22/20

MEDICAL HISTORY: (Please circle "Y" for yes or "N" for no if you have had any of the following medical problems)

High blood pressure	Y	N	COPD/asthma	Y	N	Osteoporosis	Y	N
Heart disease/attack	Y	N	HIV/AIDS	Y	N	Thyroid problems	Y	N
Stroke	Y	N	Blood clots/deep vein thrombosis (DVT)	Y	N	Depression	Y	N
Diabetes	Y	N	Hepatitis	Y	N	Fibromyalgia	Y	N
Last Hemoglobin A1C:			Cancer	Y	N	Arthritis	Y	N
Kidney problems	Y	N	Kidney stones	Y	N	Migraines	Y	N
Stomach ulcers/reflux	Y	N	Other:					

UPDATED SOCIAL HISTORY:

Employment status: Retired Unemployed Employed, job:__________ Disabled, why? __________
Tobacco use: Never Former smoker Quit date: __________ Current Packs per day: _____ Are you interested in smoking cessation information? Yes No
Alcohol use: Never Occasionally Monthly Weekly Daily
Drug use: Never Marijuana Cocaine IV drugs Other: __________

FAMILY HISTORY: (Please list any family history of medical problems, i.e. heart disease, stroke, diabetes, cancer)

Mother: __________ Father: __________

Siblings: __________ Grandparents: __________

PAST SURGICAL HISTORY: __________

PREVIOUS JOINT INJECTIONS: __________

REVIEW OF SYSTEMS: (Please circle "Y" for yes or "N" for no if you have had any of the following medical problems)

Unexpected weight loss	Y	N	Hearing/vision problems	Y	N	Difficulty swallowing	Y	N
Chest pain/palpitations	Y	N	Shortness of breath	Y	N	Joint swelling	Y	N
GI problems (GERD/diarrhea)	Y	N	Blood in urine	Y	N	Skin rash/lesions	Y	N
Allergy – food/environment	Y	N	Hallucinations	Y	N	Numbness/tingling	Y	N
Easy bleeding/bruising	Y	N	Excessive thirst	Y	N	Unsteady gait	Y	N
Diagnosed with depression	Y	N	Headaches/migraines	Y	N	History of falls	Y	N
Urine problems	Y	N	Fevers	Y	N	Safe at home	Y	N
Up to date on vaccinations	Y	N	Have you had a flu shot this year	Y	N			
Other medical concerns:								

Patient Signature: __________ Physician Signature: __________