WISSAHICKON ORTHOPAEDIC SPECIALISTS, P.C.

ACCT #: _____

PATIENT NAME: _____ DATE: _____

PAST MEDICAL HISTORY: (CHECK ALL THAT APPLY)

- ◻ ANESTHESIA PROBLEMS
- ◻ ARTHRITIS
- ◻ ASTHMA
- ◻ BLOOD CLOTS
- ◻ CANCER – TYPE: _____
- ◻ DIABETES: ◻ TYPE 1 ◻TYPE 2
- ◻ EASY BLEEDING
- ◻ EASY BRUISING
- ◻ FIBROMYALGIA
- ◻ GOUT
- ◻ HEART DISEASE
- ◻ HIGH BLOOD PRESSURE
- ◻ HIGH CHOLESTEROL
- ◻ HIV/ AIDS
- ◻ JOINT REPLACEMENT:
  LOCATION: _____
- ◻ KIDNEY DISEASE
- ◻ LIVER DISEASE
- ◻ LUNG DISEASE
- ◻ LUPUS
- ◻ OTHER: _____
- ◻ LYME DISEASE
- ◻ MULTIPLE SCLEROSIS
- ◻ MUSCULAR DYSTROPHY
- ◻ NEUROPATHY
- ◻ ORGAN TRANSPLANT: _____
- ◻ OSTEOPOROSIS
- ◻ OSTEOPENIA
- ◻ PACEMAKER
- ◻ PARKINSON'S DISEASE
- ◻ PERIPHERAL VASCULAR DISEASE
- ◻ PHLEBITIS
- ◻ PULMONARY EMBOLI
- ◻ RHEUMATOID ARTHRITIS
- ◻ SEIZURE DISORDER
- ◻ SICKLE CELL DISEASE
- ◻ SICKLE CELL TRAIT
- ◻ STOMACH ULCERS
- ◻ STROKE
- ◻ THYRIOD DISEASE ◻ HYPO ◻ HYPER
- ◻ TUBERCULOSIS

ARE YOU PREGNANT? ◻ YES ◻ NO

DID YOU HAD COVID-19 VACCINE? ◻ NO ◻ YES, DATES: _____

PAST SURGICAL HISTORY (LIST ALL MAJOR SURGERIES & DATES IF KNOWN) ◻ NO SURGERIES

_____

_____

_____

_____

ALLERGIES: ◻ NO KNOWN DRUG OR OTHER ALLERGIES ◻ YES (PLEASE LIST BELOW)

_____

_____

PLEASE CONTINUE ON BACK SIDE!

PATIENT NAME: _____ ACCT #: _____

MEDICATION LIST: (PRESCRIPTION & OVER THE COUNTER DRUGS) ☐ SEE ATTACHED LIST

NAME OF MEDICATION	DOSE & FREQUENCY	REASON

FAMILY HISTORY: (CHECK ALL THAT APPLY) ☐ NONE ☐ UNKNOWN

☐ BLOOD DISORDER ☐ CANCER- TYPE: _____

☐ DIABETES ☐ HEART DISEASE ☐ HYPERTENSION ☐ KIDNEY DISEASE

☐ OSTEOPOROSIS ☐ RHEUMATOID ARTHRITIS ☐ HEART ATTACK ☐ STROKE

☐ OTHER: _____

SOCIAL HISTORY: (CHECK ALL THAT APPLY)

DO YOU WEAR GLASSES OR CONTACTS? ☐ NO ☐ GLASSES ☐ CONTACT LENSES

DOMINANT HAND: ☐ RIGHT ☐ LEFT ☐ AMBIDEXTROUS.

TOBACCO USE: ☐ NEVER ☐ FORMER: WHEN DID YOU QUIT? _____

☐ CURRENT SMOKER: TYPE: _____ OFTEN: _____

ALCOHOL USE: ☐ NEVER ☐ OCCASIONALLY ☐ _____ # OF DRINKS PER _____

CAFFEINE USE: (DAILY BASIS) ☐ NONE ☐ OCCASIONALLY

☐ TYPES: _____ #TIMES PER DAY _____

PATIENT NAME: _____ ACCT #: _____

REVIEW OF SYSTEMS: (CHECK ALL THAT APPLY TO YOUR CHIEF COMPLAINT)

GENERAL: □ NO PROBLEM
□ UNEXPECTED WEIGHT LOSS □ UNEXPECTED WEIGHT GAIN
□ CHILLS □ FEVER □ FATIGUE

EYE: □ NO PROBLEM
□ DOUBLE VISION □ BLURRED VISION □ EYE PAIN
□ REDNESS □ WATERING □ VISUAL DISTURBANCE

EARS, NOSE, & THROAT: □ NO PROBLEM □ EARACHE
□ DIFFICULTY SWALLOWING □ NOSE BLEEDS □ RINGING IN EARS

CARDIOVASCULAR: □ NO PROBLEM
□ CHEST PAIN □ PALPITATIONS □ MURMERS □ FAINTNESS

RESPIRATORY: □ NO PROBLEM □ CHEST PAIN W/ INSPIRATION
□ SHORTNESS OF BREATH □ TIGHTNESS □ WHEEZING
□ PAIN ON BREATHING IN □ COUGHING □ SNORING

INTESTINAL: □ NO PROBLEM
□ HEARTBURN □ DIARRHEA □ CONSTIPATION □ NAUSEA
□ VOMITING □ BLOODY STOOL □ TARRY/BLACK STOOLS

URINARY: □ NO PROBLEM □ DIFFICULTY VOIDING □ FLANK PAIN
□ URINE FREQUENCY □ URINE URGENCY □ PAINFUL URINE
□ BLOOD IN URINE □ DIFFICULTLY STARTING OR STOPPING URINATION

MUSCULOSKETAL: □ NO PROBLEM
□ JOINT PAIN □ REDNESS □ SWELLING □ INSTABILITY
□ HEAT □ MUSCLE PAIN □ STIFFNESS

SKIN: □ NO PROBLEM □ URTICARIA
□ SKIN CHANGES □ ITCHING □ REDNESS □ RASH □ WOUND

NEURO: □ NO PROBLEM □ INCOORINATION □NUMBESS/TINGLING
□ DIZZINESS □UNSTEADY GAIT □ HEADACHES □ TREMOR/SEIZURES

PSYCHIATRIC: □ NO PROBLEM
□ ANXIETY □ DEPRESSION □ NERVOUSNESS □ HALLUCINATIONS

HEMATOLOGIC: □ NO PROBLEM
□ EASY BLEEDING □ EASY BRUISING □ CLOTS

ENDOCRINE: □ NO PROBLEM
□ HEAT\COLD INTOLERANCE □ EXCESSIVE THIRST □ EXCESSIVE URINATION

FOR PATIENTS 65 YEAR OR OLDER

DO YOU USE ANY WALKING DEVICES? □ CANE	□ WALKER □ WHEELCHAIR	□ NONE
DO TAKE ANY BLOOD THINNERS?	□ YES	□ NO
DO YOU HAVE A PACEMAKER?	□ YES, DATE: _____	□ NO
DO YOU EXERCISE ON A REGULAR BASIS?	□ YES	□ NO
DO YOU HAVE ADVANCED DIRECTIVES?	□ YES	□ NO
DID YOU HAVE A PNEUMONIA VACCINE?	□ YES, DATE: _____	□ NO
DID YOU HAVE A FLU VACCINE?	□ YES, DATE: _____	□ NO
DID YOU HAVE A BONE DENSITY SCAN?	□ YES, DATE: _____	□ NO

PATIENT NAME: ______________________________ ACCT #: ________________

STAFF USE ONLY

DATE: ____________	**TEMP: __________ B/P: ____________**
INITIALS: ____________	**HEIGHT: _________ WEIGHT: _________**
DATE: ____________	**TEMP: __________ B/P: ____________**
INITIALS: ____________	**HEIGHT: _________ WEIGHT: _________**
DATE: ____________	**TEMP: __________ B/P: ____________**
INITIALS: ____________	**HEIGHT: _________ WEIGHT: _________**

DATE: ____________	**TEMP: __________ B/P: ____________**
INITIALS: ____________	**HEIGHT: _________ WEIGHT: _________**
DATE: ____________	**TEMP: __________ B/P: ____________**
INITIALS: ____________	**HEIGHT: _________ WEIGHT: _________**
DATE: ____________	**TEMP: __________ B/P: ____________**
INITIALS: ____________	**HEIGHT: _________ WEIGHT: _________**

DATE: ____________	**TEMP: __________ B/P: ____________**
INITIALS: ____________	**HEIGHT: _________ WEIGHT: _________**
DATE: ____________	**TEMP: __________ B/P: ____________**
INITIALS: ____________	**HEIGHT: _________ WEIGHT: _________**
DATE: ____________	**TEMP: __________ B/P: ____________**
INITIALS: ____________	**HEIGHT: _________ WEIGHT: _________**