

Marysville Orthopedics Health Assessment  
*Please ask for assistance if you need help in completing this form*

Date: \_\_\_\_\_ Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Age \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Primary Language: English Other \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Family Physician: \_\_\_\_\_

If female, are you pregnant?  yes  no

Why are you coming to the office? (chief complaint): \_\_\_\_\_

Is your problem due to an accident?  yes  no If yes, where did accident occur?

Have you missed work because of your problem or injury?  yes  no Last day worked? \_\_\_\_\_

Allergies: Latex? <input type="checkbox"/> yes <input type="checkbox"/> no	Dyes/Contrast? <input type="checkbox"/> yes <input type="checkbox"/> no	Food
allergies:		
Medication allergies: _____		

List all medications, vitamins, and herbals including dosage and frequency:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List all prior surgeries: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Is there a history of any of these illnesses in your immediate family? (please circle) Diabetes Cancer  
High Blood Pressure Heart Disease Malignant Hyperthermia Hereditary Illness \_\_\_\_\_

**SOCIAL HISTORY**

Do you smoke?  yes  no Amt/day \_\_\_\_\_ Years \_\_\_\_\_ Quit date \_\_\_\_\_

Do you consume alcohol?  yes  no Amt/day \_\_\_\_\_

Can you take aspirin?  yes  no

Please check the appropriate category:  Married  Single  Widowed  Divorced

*-please turn over and complete the other side*

Please circle if you have now or have ever had:

<b>Cancer:</b>	Yes	No	Type(s) _____			
<b>Eyes/Ears:</b>	cataracts		glaucoma	hearing loss	hearing aids	
<b>Skin:</b>	psoriasis		easy bruising	infection		
<b>Breast:</b>	cancer		benign growth			
<b>Heart:</b>	abnormal EKG		chest pain	angioplasty	irregular heart rhythm	surgery
	CHF		heart attack	high blood pressure	heart surgery	heart transplant
	mitral valve prolapse			Rhuematic Fever		
<b>Lungs:</b>	asthma		bronchitis	COPD	emphysema	TB
	sleep apnea					
<b>GI:</b>	Hepatitis A B or C		cirrhosis	liver disease	ulcer	ulcerative colitis
	Chron's		aspirin intolerance	blood in stool		
<b>Kidney:</b>	acute or chronic renal failure			transplant	stones	dialysis
	loss of a kidney		prostate disease	frequent infections	erectile dysfunction	
<b>OB/GYN:</b>	date of last menstrual period _____					
<b>Bones &amp; Joints:</b>	back problems		osteoporosis	osteoarthritis	rheumatoid arthritis	fractures
	reflex sympathetic dystrophy			gout	lupus	fibromyalgia
<b>Neuro:</b>	stroke		tremor	headaches	seizures	numbness hands/feet
	aneurysm		paralysis	unsteady walk/falls	depression	memory loss
	mental illness		Multiple Sclerosis	Neuropathy	Parkinson's	
<b>Vascular:</b>	hemophilia		bleeding disorder	blood clots/DVT	aneurysm	anemia
	peripheral vascular disease			pulmonary embolus	varicose veins	
<b>Endocrine:</b>	Diabetes		hyperthyroidism	hypothyroidism	other	
<b>Immune System:</b>			current infection	illegal IV drugs	blood transfusion	current fever
<b>Physical Handicap:</b>	_____					

Please write here if you need additional space or have other areas of concern:

Signature of person completing form \_\_\_\_\_ Date \_\_\_\_\_

Physician signature \_\_\_\_\_ Date \_\_\_\_\_