Connecticut Valley Orthopaedics & Sports Medicine

A DEPARTMENT OF SPRINGFIELD HOSPITAL

Where People Come First

Health History Form

NAME _____

DATE OF BIRTH _____

PRIMARY CARE PHYSICIAN _____

PAST MEDICAL PROBLEMS (check all that apply):

__ Osteoarthritis
__ Rheumatoid Arthritis
__ Gout
__ Stomach/Intestinal Problems
__ COPD/Emphysema/Asthma
__ Depression/Anxiety
__ High Blood Pressure
__ Heart Problems
__ High Cholesterol
__ Phlebitis/Blood Clots
__ Osteoporosis
__ Headaches
__ Anemia
__ Hepatitis
__ Strokes
__ Dementia
__ Seizures
__ Diabetes
__ Thyroid Problems
__ Circulation Problems
__ Prolonged Bleeding
__ Cancer (Type) _____
__ Other _____
_____

PAST SURGICAL HISTORY (list orthopaedic surgeries first):

PERTINENT FAMILY HISTORY:

__ High Blood Pressure __ Asthma __ Blood Clots __ Arthritis (type, if known) _____
__ Heart Disease __ Diabetes __ Spine Problems __ Other _____
__ Strokes __ Kidney Disease __ Cancer (type, if known) _____

REVIEW OF SYSTEMS (Check any of the following symptoms that you have had within the past year):

GENERAL:
__ Tire easily
__ Fever/Chills
__ Weight loss/gain

CARDIAC:
__ Chest pain
__ Palpitations
__ Swelling in legs

INTEGUMENT:
__ Rash
__ Skin disorders/Infections

GI/GU:
__ Heartburn
__ Nausea/Vomiting
__ Diarrhea
__ Constipation
__ Painful urination
__ Incontinence

HEMAT/ENDO:
__ Bruise easily
__ Blood clots

NEUROLOGICAL:
__ Dizziness
__ Frequent headaches

MENTAL HEALTH:
__Change in sleep
__Depression

RESPIRATORY:
__ Shortness of breath
__ Cough

HEENT:
__ Nosebleeds
__ Loose teeth/Cavities

MUSCULOSKELETAL:
__ Morning stiffness

Patient Signature: _____ **Date:** _____ **Provider Initials:**_____ **Date:**_____