Name:
DOB:
Chart:
Appt Date:

ADVANCED JOINT REPLACEMENT CENTER OF SOUTHERN OREGON

PATIENT CONFIDENTIAL HEALTH HISTORY

Primary Care Physician:_____ Referring Physician:_____ Pain Specialist:_____

Reason for today's visit: _____

Social Status: (Circle) Married Single Divorced Widowed

Result of a (n): Accident _____ Other_____

Date of Onset _____ Occupation_____

Have you had any of the following Diagnositc Tests? If so, please indicate when and where:

CT Scan_____ MRI_____ EMG_____ XRAY_____ Bone Density_____

Past/Present Illnesses: Please **circle** illnesses you have had or have now:

Diabetes	Anemia	Stomach Ulcers	Epilepsy
Heart Disease	Eye Disease	Head Injury	Migraine
High Blood Pressure	Arthritis	Liver Disease/Hepatitis	Bowel Disease
Immune-deficiencies	Cancer/type_____	Pneumonia	Alcoholism
Blood Clots	Radiation	Depression	Tuberculosis
Cortisone Therapy	Rheumatic Fever	Drug Abuse	Asthma
COPD	Kidney Disease	Gallbladder Disease	Stroke
Bleeding Problems	Thyroid Disease	Sleep Apnea	

Other_____

Past Surgeries/Hospitalizations	**Year**	**Complications**

Presently taking any **Anticoagulants** (blood thinners)?	Yes No List: _____
Presently taking **Fish oil?**	Yes No
Have you ever had general anesthesia?	Yes No
Any problems with anesthesia?	Yes No List: _____
Do you have an allergy to **Latex?**	Yes No
Do you have food allergies?	Yes No List: _____
Are you pregnant now? (if applicable)	Yes No
First day of last menstrual period (if applicable)	Date: _____
Allergies/Sensitivities to medications?	Yes No List: _____

Please turn over…->