Washington Township Medical Foundation
Part of Washington Hospital Healthcare System

HISTORY FORM

Ht._____ Wt._____ BP_____ Pulse_____ Temp._____ Pain_____

Please complete this form before seeing your doctor. Appointment Date _____

Name_____ Age_____ ☐ Male ☐ Female Last Period_____

Are you currently working? ☐ Yes ☐ No ☐ Regular ☐ Light Duty Last date worked_____

Occupation_____

Employer_____

Reason for Visit_____

Does your orthopaedic problem affect your ability to work? ☐Yes ☐ No ☐ Right Handed ☐ Left Handed ☐ Ambidextrous

Primary Care Physician_____

Referring Physician_____

Please list all of your current medications:

Medication	Dosage (mg)	How Often	Prescribed By

Allergies to medications:

Medication	Type of Reaction

Are you allergic to latex? ☐ Yes ☐ No

PAST MEDICAL HISTORY

Please check any of the conditions below which you have had:

YES	NO		YES	NO		YES	NO	
☐	☐	Anemia	☐	☐	Diabetes Type 2	☐	☐	Mental Illness
☐	☐	Asthma (493.9)	☐	☐	Diverticulitis (562.11)	☐	☐	Neurological Problems
☐	☐	Bleeding Disorder	☐	☐	Emphysema (492.8)	☐	☐	Pacemaker
☐	☐	Blood Clot Formation (453.8)	☐	☐	Gastritis (535.50)	☐	☐	Pulmonary Embolus (415.11)
☐	☐	Cancer/Type_____	☐	☐	Heart Attack (419.90)	☐	☐	Rheumatoid Arthritis
☐	☐	Chemical Dependency (Abuse)	☐	☐	Heart Problems	☐	☐	Season Allergies
☐	☐	Cirrhosis (571.2)	☐	☐	Hepatitis (070.9)	☐	☐	Stomach Ulcer (531.9)
☐	☐	Degenerative Arthritis	☐	☐	High Blood Pressure (410.9)	☐	☐	Stroke (434.91)
☐	☐	Depression (296.2)	☐	☐	Immune Deficiency	☐	☐	Thyroid Disease
☐	☐	Diabetes Type 1	☐	☐	Kidney Disease	☐	☐	Tuberculosis (011.90)

☐ Other_____

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HISTORY FORM

Patient Name:_____

Appointment Date_____

Please list any other medical problems for which you are currently under treatment:

Condition	Treating Physician	Date last seen by doctor

Please list every operation that you have had, including the year, surgeon and hospital, if possible:

Surgery	Year	Surgeon	Hospital

Please list all other hospitalizations or injuries:

_____

_____

_____

_____

_____

FAMILY HISTORY

Do/did any of your brothers/sisters, parents or grandparents have any of the following (describe):

Rheumatoid Arthritis _____ Heart Attack _____

Other Joint Problems _____ Cancer _____

Bleeding Problems _____ Diabetes_____

Anesthesia Problems _____ Stroke _____

Mental Illness _____ Thyroid _____

SOCIAL HISTORY

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated Where were you born?_____

How many people live in your household? _____How are they related?_____

Do you have stairs at home? ☐ Yes ☐ No ☐ Inside ☐ Outside

Habits

Alcohol? ☐ Yes ☐ No Drinks per week _____

Drugs? ☐ Yes ☐ No Times per week _____ Type_____

Tobacco? ☐ Yes ☐ No ☐ Former Years _____ Packs/day_____ Quit Date _____
☐ Ready to Quit ☐ Counseled

Smokeless Tobacco? ☐ Yes ☐ No ☐ Former Years _____ Times/day_____ Quit Date _____
☐ Ready to Quit ☐ Counseled

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Patient Name:_____

Appointment Date_____

REVIEW OF SYSTEMS

Do you experience any of the following? If yes, please describe. If no, check no.

Constitutional Symptoms:

Fatigue ☐ Yes ☐ No
Fever ☐ Yes ☐ No
Weight loss ☐ Yes ☐ No

Describe _____

Eyes:

Blurring ☐ Yes ☐ No
Cataract ☐ Yes ☐ No
Change in Vision ☐ Yes ☐ No
Double vision ☐ Yes ☐ No
Glasses ☐ Yes ☐ No
Glaucoma ☐ Yes ☐ No
Trauma ☐ Yes ☐ No

Describe _____

ENT & Mouth:

Deafness ☐ Yes ☐ No
Dizziness ☐ Yes ☐ No
Hoarseness ☐ Yes ☐ No
Ringing in the ears ☐ Yes ☐ No
Sinusitis ☐ Yes ☐ No

Describe _____

Respiratory:

Asthma ☐ Yes ☐ No
Chronic lung disease ☐ Yes ☐ No
Cough ☐ Yes ☐ No
Cough up blood ☐ Yes ☐ No
Shortness of breath ☐ Yes ☐ No

Describe _____

Cardiovascular:

Chest pain ☐ Yes ☐ No
Hypertension ☐ Yes ☐ No
Irregular beats ☐ Yes ☐ No
Palpitations ☐ Yes ☐ No

Describe _____

Gastrointestinal:

Abdominal pain ☐ Yes ☐ No
Appetite change ☐ Yes ☐ No
Diarrhea/Constipation ☐ Yes ☐ No
Vomit Blood ☐ Yes ☐ No
Black or bloody stool ☐ Yes ☐ No
Nausea/Vomiting ☐ Yes ☐ No
Weight change ☐ Yes ☐ No

Describe _____

Genitourinary:

Difficulty passing urine ☐ Yes ☐ No
Genital Masses ☐ Yes ☐ No
Incontinence ☐ Yes ☐ No
Painful urination ☐ Yes ☐ No
Menstrual history/Pregnancies

Describe _____

Integumentary/Breast:

Change in color/temp ☐ Yes ☐ No
Lesions/Scars ☐ Yes ☐ No
Masses ☐ Yes ☐ No
Rashes ☐ Yes ☐ No
Ulcers ☐ Yes ☐ No

Describe _____

Hematologic/Lymphatic:

Bleeding tendency ☐ Yes ☐ No
Easy Bruising ☐ Yes ☐ No
Lymph node pain/enlargement ☐ Yes ☐ No
Anemia ☐ Yes ☐ No

Describe _____

Musculoskeletal:

Arthritis ☐ Yes ☐ No
Fractures/Sprains ☐ Yes ☐ No
Joint Pain ☐ Yes ☐ No
Joint Swelling ☐ Yes ☐ No
Muscle wasting ☐ Yes ☐ No
Stiffness ☐ Yes ☐ No

Describe _____

Neuro:

Balance/Incoordination problems ☐ Yes ☐ No
Changes in sensation ☐ Yes ☐ No
Numbness/tingling ☐ Yes ☐ No
Seizures ☐ Yes ☐ No
Speech & swallowing difficulty ☐ Yes ☐ No
Stroke ☐ Yes ☐ No
Visual changes ☐ Yes ☐ No
Weakness ☐ Yes ☐ No

Describe _____

Pysch:

Depression ☐ Yes ☐ No
Hallucinations ☐ Yes ☐ No
Mood swings ☐ Yes ☐ No
Sleep disturbances ☐ Yes ☐ No

Describe _____

Endocrine:

Frequent hunger ☐ Yes ☐ No
Frequent thrist ☐ Yes ☐ No
Growth/hair changes ☐ Yes ☐ No
Hyper/hypoactivity ☐ Yes ☐ No

Describe _____

Allergic/Immunologic:

Dermatitis/Eczema/Itching ☐ Yes ☐ No
Environmental Allergies ☐ Yes ☐ No
Reactions to rubber gloves ☐ Yes ☐ No
Skin reactions ☐ Yes ☐ No

Describe _____

Signature_____