Health History

Patient Information Sheet

Patient name: Today's Date: / /

PATIENT INFORMATION:

Patient name: DOB: / / Age: Today's Date: / /

Height:
Weight:
R ☐ L ☐ Handed ☐ Male ☐ Female Are you or might you be pregnant? ☐ Y / ☐ N

Employer: Occupation:

Reason for today's visit:

Who is your primary care physician?

Date of injury or onset of problem?

Area of the body involved?
☐ Right side / ☐ Left side

Is this work related? ☐ Y / ☐ N Workmen's comp claim filed? ☐ Y / ☐ N

Have X-Rays been taken? ☐ Y / ☐ N Where? When?

Previous similar complaint? ☐ Y / ☐ N Have you returned to work? ☐ Y / ☐ N When?

ALLERGIES: Are you allergic to ANY drugs? ☐ No ☐ Yes list all DRUG ALLERGIES including reactions

Are you allergic to: (*) Note reactions to all yes answers		Drug:	Reaction:
Eggs	☐ Y* / ☐ N		
Iodine	☐ Y* / ☐ N		
Latex	☐ Y* / ☐ N		
Sulfa	☐ Y* / ☐ N		
Nuts	☐ Y* / ☐ N		
Tape	☐ Y* / ☐ N		
Penicillin	☐ Y* / ☐ N		

CURRENT MEDICATIONS: Do you take any medication? ☐ No / ☐ Yes List all, including Over the Counter Meds, Herbs and Vitamins

Drug name / strength	Dose	Prescribing Physician	Drug name / strength	Dose	Prescribing Physician

Have you ever had a cortisone injection? ☐ Y / ☐ N Area injected?

SURGICAL HISTORY: Have you undergone any surgical procedures? ☐ No / ☐ Yes List all surgeries, include left or right when indicated:

Year	Surgery	Year	Surgery	Year	Surgery

ANESTHESIA: Have you ever had problems with anesthesia? ☐ No / ☐ Yes Explain.

Health History

richard pearis MD
ARIZONA ARTHROSCOPY AND SPORTS MEDICINE

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Patient name: Today's Date: / /

MEDICAL HISTORY: List all current medical conditions under treatment ☐ None

Condition	Treating Physician	Condition	Treating Physician

REVIEW OF SYSTEMS: Are you currently having or have you ever had problems with:

	No	Yes		No	Yes		No	Yes
Allergies (Hay fever)	☐	☐	Fibromyalgia	☐	☐	Neurological Problems	☐	☐
Anemia	☐	☐	Gallstones	☐	☐	Numbness / tingling	☐	☐
Arthritis	☐	☐	Glaucoma	☐	☐	Old Fractures	☐	☐
Asthma	☐	☐	Gout	☐	☐	Osteoarthritis	☐	☐
Balance	☐	☐	Heart Disease	☐	☐	Osteomyelitis	☐	☐
Birth Defect	☐	☐	Hepatitis / Jaundice	☐	☐	Osteoporosis	☐	☐
Blackout / Fainting	☐	☐	High Blood Pressure	☐	☐	Polio	☐	☐
Bladder	☐	☐	High Cholesterol	☐	☐	Rheumatic Fever	☐	☐
Bleeding	☐	☐	HIV / AIDS	☐	☐	Rheumatoid Arthritis	☐	☐
Blood Clots	☐	☐	Joint Swelling	☐	☐	Shingles	☐	☐
Cancer	☐	☐	Kidney Stones	☐	☐	Sickle Cell	☐	☐
Chest pain	☐	☐	Liver Problems	☐	☐	Stomach / Ulcers	☐	☐
Depression	☐	☐	Lung Problems	☐	☐	Stroke	☐	☐
Diabetes	☐	☐	Mental Illness	☐	☐	Thyroid Disease	☐	☐
Emphysema	☐	☐	Migraine Headaches	☐	☐	Tuberculosis (TB)	☐	☐
Epilepsy or Seizures	☐	☐	Multiple Sclerosis	☐	☐	Poor Wound Healing	☐	☐
						Other (describe below):	☐	☐

Describe all YES responses and give details to OTHER responses:

Family History:

	None	Mother	Father	Siblings		None	Mother	Father	Siblings
Asthma	☐	☐	☐	☐	Mental Illness	☐	☐	☐	☐
Bleeding Disorders	☐	☐	☐	☐	Osteoarthritis	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	Rheumatoid Arthritis	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	Seizures	☐	☐	☐	☐
DVT (Blood Clots)	☐	☐	☐	☐	Sickle Cell	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	Stroke	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	Thyroid Disease	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	Tuberculosis	☐	☐	☐	☐
					Other (describe below):	☐	No	☐	Yes

Describe all YES responses and give details to OTHER responses:

richard pearis MD
ARIZONA ARTHROSCOPY AND SPORTS MEDICINE

Patient name: _____ Today's Date: ___/___/___

SOCIAL HISTORY:

Do you smoke tobacco? ☐ No ☐ Yes If yes, _____ Packs per day for _____ Years

Did you quit smoking tobacco? ☐ No ☐ Yes When? _____
Previously smoked _____ Packs per day for _____ Years

Do you chew tobacco? ☐ No ☐ Yes How Often? _____

Do you drink alcohol? ☐ No ☐ Yes How Much? _____
How Often? _____

Do you live alone? ☐ No ☐ Yes Do you have children? ☐ Yes / ☐ No
How Many? _____

Do you use walking aids? ☐ No ☐ Yes ☐ Cane ☐ Crutches ☐ Walker ☐ Other

Have you ever abused drugs or alcohol? ☐ No ☐ Yes If "Yes", Explain _____

Do you exercise? ☐ Never ☐ Rarely ☐ Weekly ☐ Daily ☐ Type? _____

Patient Signature: _____ **Date** _____ **Update** _____ **by** _____

Reviewed by: _____ **Date** _____ **Update** _____ **by** _____

MD Signature _____ **Date** _____ **Update** _____ **by** _____

Reviewed by	Date	Reviewed by	Date	Reviewed by	Date