

# HSE Orthopaedic Surgery Clinic PA

Haissam El-Zaim MS, MD, PhD

## Patient History Form

**It is very important that you fill in all the blanks on this form.**

Date: \_\_\_\_\_  
 Full Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_  
 SS# \_\_\_\_\_ Birth date: \_\_\_\_\_ Age: \_\_\_\_\_ M \_\_\_\_\_ F \_\_\_\_\_  
 Race: White \_\_\_\_\_ Black \_\_\_\_\_ Hispanic \_\_\_\_\_ Asian \_\_\_\_\_ Other \_\_\_\_\_  
 Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Who referred you to our office? \_\_\_\_\_  
 Primary Care Physician: \_\_\_\_\_ Specialist: \_\_\_\_\_

<b>LIST ALL ALLERGIES AND REACTIONS</b> (Food, Drug, Metal, Tape)	1. _____ 2. _____ 3. _____ 4. _____	NONE
--	--	------

<b>LIST ALL MEDICATIONS YOU NOW TAKE</b> (Including Vitamins and any and all over the counter drugs and diet pills)	1. _____ 2. _____ 3. _____ 4. _____	5. _____ 6. _____ 7. _____ 8. _____
--	--	--

<b>LIST ALL OPERATIONS</b>	1. _____ 2. _____ 3. _____ 4. _____	5. _____ 6. _____ 7. _____ 8. _____
----------------------------	--	--

What is your occupation?	
--------------------------	--

**ANESTHESIA**

1. Have you ever had anesthesia? YES NO  
 WHAT TYPE? Local General Regional

2. Have you ever had a problem with anesthesia? YES NO What? \_\_\_\_\_

3. Any family history of malignant hyperthermia or unexpected death under anesthesia?

**RESPIRATORY**

4. Do you smoke? YES NO  
 (How many packs per day \_\_\_\_\_ How many years? \_\_\_\_\_)

5. Do you currently have a cough? YES NO

6. Have you ever had asthma? YES NO  
 When was your last attack? \_\_\_\_\_

7. Do you currently or chronically have bronchitis, sinusitis, or emphysema? YES NO  
 When was your last attack? \_\_\_\_\_

8. Have you ever had tuberculosis? YES NO (If yes, how was it treated? \_\_\_\_\_)

9. Have you ever had an abnormal chest x-ray? YES NO (When? \_\_\_\_\_)

10. Have you ever been diagnosed with sleep apnea?  
 Do you ever stop breathing at night? YES NO  
 Do you snore loudly? YES NO

**GENERAL**

1. Have you ever been under the care of a psychiatrist? YES NO

2. Have you given blood for the hospitalization? YES NO

3. Has someone else given blood for you? YES NO

4. Do you wear glasses or contacts? YES NO

5. Have you ever had cancer? YES NO

<b>SOCIAL</b>	<b>YES</b>	<b>NO</b>	<b>COMMENTS</b>
1. Alcohol use?			
2. Do you use any recreational drugs?			
3. Do you have any hobbies/interests/play sports?			
<b>FAMILY HISTORY</b>			
4. Are there any diseases in your family? (Diabetes, High Blood Pressure, Heart Attack, Cancer, etc.			
<b>RENAL</b>			
5. Do you have any problems urinating?			
6. Have you ever had kidney disease?			
<b>CARDIOVASCULAR</b>			
7. Do you exercise regularly?			
8. Are you short of breath at night or walking two flights of stairs?			
9. Do you have any swelling in your legs?			
10. Do you have a heart murmur?			
11. Have you ever had a heart attack?			
12. Have you ever had angina or pain in the chest related to your heart?			
13. Have you ever had an abnormal EKG?			
14. Have you ever had high blood pressure?			
<b>NEUROLOGICAL</b>			
15. Have you ever had a stroke?			
16. Have you ever had seizures, episodes of unconsciousness, or fainting?			
17. Do you have an arm or leg that becomes numb, weak, or swells?			
18. Have you ever had an eye problem, problem with your vision or glaucoma?			
<b>GASTROINTESTINAL</b>			
19. Do you have any ulcers?			
20. Do you have reflux, frequent heartburn, indigestion?			
21. Do you have blood in your stool?			
22. Have you ever had hepatitis, liver disease or been jaundiced?			
<b>ENDOCRINE</b>			
23. Have you been on steroids anytime in the past six months?			
24. Do you have diabetes?			
25. Have you ever had a thyroid problem?			
<b>MUSCULOSKELETAL</b>			
26. Do you have back or neck problems?			
27. Do you have arthritis?			
<b>OTHER</b>			
28. Any skin problems? Lesions?			
29. Any history of sexually transmitted diseases? Or any contagious illness?			
30. Are you taking a blood thinner? (Aspirin or Coumadin)			
31. Have you ever had a blood clot?			
32. Have you ever been anemic?			
33. Do you have a chipped or loose teeth, dentures, caps, bridgework?			
<b>FEMALES</b>			
34. Are you pregnant?			
35. When was your last period?			

Name of your family or medical physician: \_\_\_\_\_ Phone # \_\_\_\_\_

Specialty: \_\_\_\_\_ Address: \_\_\_\_\_

Any Other Physician: \_\_\_\_\_ Phone# \_\_\_\_\_

Specialty: \_\_\_\_\_ Address: \_\_\_\_\_

I am giving Dr. El-Zaim permission for treatment of my orthopedic problem

Patient's Signature: \_\_\_\_\_