St. Lawrence Health System
Canton-Potsdam Hospital

50 Leroy Street
Potsdam, NY 13676
PH: (315) 265-3300

Physician Practice Management - Orthopedics and Sports Medicine

Health History Form

Patient Name _____ Birthdate _____

Today's Date_____ Reason for Visit _____

If this is a re-visit to our office for a new problem, list any changes to your health, medications or allergies since your last visit: _____

_____

Primary Physician: _____ Referring Physician: _____

Dominant Hand: ☐ Left ☐ Right Height: _____ Weight: _____

Date of Injury/Onset of Symptoms: _____ Which side is the injury? ☐ Left ☐ Right ☐ Bilateral

Please describe where and how your injury happened? _____

_____

Have you had treatment for this problem before? ☐ Yes ☐ No By Whom? _____

When and where were you treated? _____

Did you have X-Rays taken? ☐ Yes ☐ No Where? _____

Were you put on medications for this problem? ☐ Yes ☐ No What medications? _____

Are you still taking this medication? ☐ Yes ☐ No

What increases your pain and/or symptoms? _____

What decreases your pain and/or symptoms? _____

What is your current work status?

☐ No restrictions ☐ Working w/restrictions ☐ Off-Duty ☐ Disabled ☐ Unemployed ☐ Homemaker ☐ Retired ☐ Student

If you are not working, what was the last day you worked? _____

What is your occupation? _____

SOCIAL HISTORY							
DO YOU USE ANY OF THE FOLLOWING? – Please circle all applicable							
TOBACCO	Y	N	Packs per Day?	**CAFFEINE**	Y	N	How much/often?
ALCOHOL	Y	N	Drinks per Week?	**STREET DRUGS**	Y	N	How much/often?

Marital Status: (circle one) Married Divorced Single Widowed Separated

Do you Exercise? YES or NO How often/much? _____

FAMILY HISTORY						
CONDITION	PLEASE SPECIFY:	MOTHER	FATHER	BROTHER	SISTER	CHILD
ARTHIRITIS						
BONE DISEASE						

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SURGICAL HISTORY/HOSPITALIZATIONS		
YEAR	HOSPITAL	REASON AND OUTCOME

DO YOU CURRENTLY HAVE OR HAVE HAD ANY OF THE FOLLOWING?							
	(✔)		(✔)		(✔)		(✔)
Abdominal Pain		CHF		Heart Murmur		Prostate Problem	
AIDS		COPD		High Cholesterol		Psychiatric Care	
Alcoholism		Crohns Disease		HIV Positive		Pulmonary Embolism	
Anemia		Depression		IBS		Rheumatic Fever	
Anorexia		Diabetes		Infertility		Rheumatoid Arthritis	
Anxiety		Eating Disorder		Joint Pain		Scarlet Fever	
Appendicitis		Emphysema		Keloids		Seizures	
Arthritis		Epilepsy		Kidney Disease		Sleep Apnea	
Asthma		Fever		Liver Disease		Stroke	
Atrial Fibrillation		Gallbladder Disease		Lupus		Suicide Attempt	
Bi-Polar Disorder		Gastrointestinal Bleeding		Measles		Swallowing Disorder	
Bleeding Disorders		GERD (acid reflux)		Migraine Headaches		Thyroid Problems	
Blood Clots		Glaucoma		Miscarriage		Tonsillitis	
Breast Lump		Goiter		Mononucleosis		Tuberculosis	
Bronchitis		Gonorrhea		Multiple Sclerosis		Typhoid Fever	
Bulimia		Gout		Mumps		Ulcerative Colitis	
Cancer		Heart Disease		Numbness in arm/leg		Vaginal Infections	
Cataracts		Hemorrhoids		Pacemaker		Venereal Disease	
Celiac Disease		Hepatitis, Type _____		Peptic Ulcer Disease		Weight Gain	
Chemical Dependency		Hernia		Pneumonia		Weight Loss	
Chicken Pox		Herpes		Polio			

MEDICATIONS: Please list all medications with their dosages that you are currently taking.

_____

_____

_____

ALLERGIES: Please list all allergies to medications/foods/latex:

_____

_____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

(PRINT) Patient/Authorized Representative Date (SIGN) Patient/Authorized Representative Date