Name: _____

Date of Birth: _____

Date: _____

GVH GRAND VIEW HEALTH

UPPER BUCKS ORTHOPAEDICS AT GRAND VIEW HEALTH

ALLERGIES: Please list all Medication allergies and the reaction to that medication(s) ☐ **No Known Allergies**

MEDICATION	***REACTION***

Medications: Please list all medications you take on a daily basis, including over the counter medication (including vitamins and herbal supplements) and birth control pills OR: ☐ No Medications Taken

Name of Medication	**Dosage (mg, units, etc.)**	**How Often Taken**

Past Medical History: Please check all that apply: ☐ **No known Medical Conditions**

- ☐ History of MRSA
- ☐ Diabetes
- ☐ Bleeding Disorder
- ☐ Pulmonary Embolism
- ☐ DVT (blood clot in leg)
- ☐ Hyperthyroid
- ☐ Leukemia/Lymphoma
- ☐ Sleep Apnea/CPAP
- ☐ Hiatal Hernia
- ☐ Stomach Ulcers
- ☐ Coronary Artery Disease
- ☐ Pacemaker
- ☐ Heart Murmur
- ☐ Stroke
- ☐ High Blood Pressure
- ☐ Asthma
- ☐ Emphysema/COPD
- ☐ Irritable Bowel
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Peripheral Vascular Disease
- ☐ Kidney Stones
- ☐ High Cholesterol
- ☐ Reflux
- ☐ Heart Attack
- ☐ Hepatitis
- ☐ Liver Disease
- ☐ Anxiety
- ☐ Depression
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Migraines
- ☐ Benign Prostatic Hypertrophy
- ☐ Rheumatoid Arthritis
- ☐ Cancer: Type _____
- ☐ Osteoporosis
- ☐ Osteopenia
- ☐ Other: _____

Past Surgical History: Please check all prior surgeries you have had and specify type:

- ☐ NO PRIOR SURGERIES
- ☐ AICD/Pacemaker
- ☐ Angioplasty/stent
- ☐ Hand surgery: _____
- ☐ Knee surgery: _____
- ☐ Foot: _____
- ☐ Ankle: _____
- ☐ Tonsillectomy/adenoidectomy
- ☐ Other Heart: _____
- ☐ Vascular: _____
- ☐ Shoulder: _____
- ☐ Spine: _____
- ☐ Eye: _____
- ☐ Hip: _____
- ☐ Breast: _____
- ☐ Appendectomy
- ☐ C-section
- ☐ Wisdom teeth
- ☐ Gallbladder
- ☐ Hernia repair
- ☐ Hysterectomy

☐ Other Surgeries: _____

Name: ______________________________

Date of Birth: ____________

Date: ____________

GVH GRAND VIEW HEALTH

UPPER BUCKS ORTHOPAEDICS AT GRAND VIEW HEALTH

Family History: Check any of the following diseases that are in your immediate family:

Mother	Father	Brother	Sister	Son	Daughter
☐None	☐None	☐None	☐None	☐None	☐None
☐Cancer	☐Cancer	☐Cancer	☐Cancer	☐Cancer	☐Cancer
☐Bone Cancer	☐Bone Cancer	☐Bone Cancer	☐Bone Cancer	☐Bone Cancer	☐Bone Cancer
☐Lung Disease	☐Lung Disease	☐Lung Disease	☐Lung Disease	☐Lung Disease	☐Lung Disease
☐Diabetes	☐Diabetes	☐Diabetes	☐Diabetes	☐Diabetes	☐Diabetes
☐Rheumatoid Arthritis	☐Rheumatoid Arthritis	☐Rheumatoid Arthritis	☐Rheumatoid Arthritis	☐Rheumatoid Arthritis	☐Rheumatoid Arthritis
☐Heart Disease	☐Heart Disease	☐Heart Disease	☐Heart Disease	☐Heart Disease	☐Heart Disease
☐Anesthesia Complications	☐Anesthesia Complications	☐Anesthesia Complications	☐Anesthesia Complications	☐Anesthesia Complications	☐Anesthesia Complications

Social History: Check one that applies

Marital status:	☐Married	☐Single	☐Divorced	☐Separated	☐Widowed
Employment:	☐Student	☐Unemployed	☐Employed	☐Retired	☐Disabled
Tobacco History:	☐Never a Smoker	☐Daily Smoker	☐Occasional Smoker	☐ Former Smoker	
Alcohol History:	☐Never Drinks	☐Currently Drinks	☐Drank in past only		

Please check the reason for **today's appointment**: Include Right (R), Left (L) or Both (B) where applicable

Hip	☐L ☐R ☐B	Groin	☐L ☐R ☐B	Pelvis	☐
Thigh	☐L ☐R ☐B	Shin	☐L ☐R ☐B	Finger:	____________
Shoulder	☐L ☐R ☐B	Clavicle	☐L ☐R ☐B	Upper Arm	☐L ☐R ☐B
Elbow	☐L ☐R ☐B	Forearm	☐L ☐R ☐B	Toe:	____________
Hand	☐L ☐R ☐B	Wrist	☐L ☐R ☐B	Heel	☐L ☐R ☐B
Knee	☐L ☐R ☐B	Calf	☐L ☐R ☐B	Back	☐Upper ☐Middle ☐Lower
Ankle	☐L ☐R ☐B	Foot	☐L ☐R ☐B	Neck	☐

Other: ______________________________________

Date of Injury/When Symptoms Started: ____________ Where injury occurred: ____________________

Work Related? ☐ Yes ☐ No Motor Vehicle Accident? ☐ Yes ☐ No

Describe, **in DETAIL**, injury or reason for visit: ______________________________________

____

Did you have any prior studies related to this visit? ☐ Yes ☐ No If yes, where? ____________________

REVIEW OF SYSTEMS: Have you had any of the following in the **last 6 months**? Please answer at **each** category.

Constitutional: ☐ none ☐weight loss ☐weight gain ☐ fever ☐ chills ☐ snoring

Eyes: ☐none ☐vision change ☐ blurred vision ☐ eye pain

Ears/Nose/Throat/Neck: ☐ none ☐sore throat ☐ nose bleeds ☐ dizziness

Cardiovascular: ☐ none ☐ chest pain ☐ palpitations ☐ shortness of breath ☐ light headed when standing

Respiratory: ☐ none ☐ wheezing ☐ chest congestion ☐ coughing up blood ☐ cough

Gastrointestinal: ☐ none ☐ constipation ☐ frequent diarrhea ☐ vomiting ☐ abdominal pain

Genitourinary: ☐ none ☐ urinary incontinence ☐ hematuria (blood in urine) ☐ urinary frequency/urgency

Musculoskeletal: ☐ none ☐ muscle weakness ☐ stiffness ☐ arthralgias (joint pain) ☐ back pain

Integumentary: ☐ none ☐ rash ☐ lesions ☐ wounds ☐ skin ulcer

Neurologic: ☐ none ☐ weakness ☐ tremor ☐ memory loss ☐ convulsions ☐ tingling ☐ numbness

Psychological: ☐ none ☐ anxiety ☐ depression ☐ memory loss ☐ confusion

Endocrine: ☐ none ☐ fatigue ☐ flushing ☐ heat intolerance ☐ cold intolerance

Hematologic / Lymphatic: ☐ none ☐ abnormal bleeding ☐ easy bruising ☐ swollen glands