Fletcher Allen HEALTH CARE
In alliance with The University of Vermont

Orthopaedics and Rehabilitation
Adult Joint Reconstruction Service

David A Halsey, MD

PATIENT INFORMATION

Today's Date:
Time:

Phone: _____ Best time to call: _____

Primary Care MD _____
Address: _____

Phone: _____

Referring MD _____
Address: _____

Phone: _____

"YOUR HEALTH HISTORY"

Current Height ___ ft ___ in Weight _____ lbs

Please list any current medical problems or previous illnesses requiring hospitalization

_____

_____

_____

_____

SURGICAL HISTORY

Surgery	Year	Complications (if any)

MEDICATIONS

Please list your current medications including herbal supplements _____

_____

_____

_____

Do you take any blood thinners (Coumadin, Plavix)? ☐ Yes ☐ No
If yes, list here: _____
Do you take oral contraceptives (birth control pills)? ☐ Yes ☐ No
If yes, list here: _____

ALLERGIES TO MEDICATIONS (please list medication and reaction, if known)

_____

_____

Do you have a latex allergy? ☐ Yes ☐ No

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FAMILY HISTORY

	You?		Family?	
	Yes	No	Yes	No
Deep Venous Thrombosis (blood clots)				
Bleeding problems				
Inflammatory Arthrits (i.e. Rheumatoid Arthritis)				
Auto-Immune diseases (i.e. Lupus)				
Connective Tissue Disorders (i.e. Marfan's, Ehler-Danlos)				
Other orthopaedic problems				
Heart Disease?				
Diabetes?				

SOCIAL HISTORY

Occupation _____ Currently working? ☐ Yes ☐ No

If no, date last worked? _____

Do you smoke? ☐ Yes, I've smoked _____ packs of cigarettes per day for_____ years

☐ Yes, I smoke cigars, pipe, or chew tobacco

☐ No, I have never smoked ☐ No, I quit ____ years ago

Do you drink alcohol? ☐ Yes ☐ No

If yes, how often? ☐ Daily ☐ 1 or more times/week ☐ 1 or more times/month

What exercises do you like to do? _____

_____

_____

REVIEW OF SYSTEMS

Are you currently, or have you ever had problems with:

CONSTITUTIONAL	CIRCLE ONE	
Unexpected Weight Loss	Yes	No
Excessive Fatigue	Yes	No
Night Sweats	Yes	No
Loss of appetite	Yes	No
EYES		
Wear Glasses or Contacts	Yes	No
Infections	Yes	No
Injuries	Yes	No
EAR, NOSE, THROAT & MOUTH		
Wear Hearing Aids?	Yes	No
Date of last Exam: _____		
Hearing Loss	Yes	No
Ear Infections	Yes	No
Balance Disturbance	Yes	No
Sinus Problems	Yes	No

CARDIOVASCULAR	CIRCLE ONE	
Chest Pain or Angina	Yes	No
Date of Last EKG: _____		
High Blood Pressure	Yes	No
Irregular Pulse	Yes	No
Heart Murmur	Yes	No
Heart Attack	Yes	No
Blood Clots	Yes	No
RESPIRATORY		
Asthma	Yes	No
Chronic Cough	Yes	No
Emphysema	Yes	No
Shortness of Breath	Yes	No
Bronchitis	Yes	No
Pneumonia	Yes	No
Lung Cancer	Yes	No
Tuberculosis	Yes	No

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REVIEW OF SYSTEMS (Continued)

Are you currently, or have you ever had problems with:

GASTROINTESTINAL	CIRCLE ONE	
Nausea	Yes	No
Vomiting	Yes	No
Ulcers or Gastritis	Yes	No
Colon Cancer	Yes	No
Stomach Ulcer	Yes	No
Hepatitis	Yes	No
GENITOURINARY		
Urinary Tract Infections	Yes	No
Kidney Stones	Yes	No
Kidney Disease	Yes	No
MUSCULOSKELETAL		
Broken Bones	Yes	No
Arm or Leg Weakness	Yes	No
Back Pain	Yes	No
Arm or Leg Pain	Yes	No
Joint Pain or Swelling / Arthritis	Yes	No
Numbness	Yes	No
Osteoporosis	Yes	No
Instability / giving way / dislocation	Yes	No
Stiffness	Yes	No
Scolosis	Yes	No
Spinal Conditions	Yes	No
INTEGUMENTARY		
Skin Cancer	Yes	No
Skin Ulcers	Yes	No

ENDOCRINE	CIRCLE ONE	
Diabetes	Yes	No
Treatment: _____		
Thyroid Disease / Disorder	Yes	No
Hormone Problems	Yes	No
HEMATOLOGIC / LYMPHATIC		
Anemia	Yes	No
Hemophilia	Yes	No
Bleeding Tendencies	Yes	No
Persistent Swollen Glands/Lymph Nodes	Yes	No
Blood Transfusion	Yes	No
If yes, when? _____		
Easy bleeding	Yes	No
Easy bruising	Yes	No
Cancer	Yes	No
ALLERGIC/IMMUNOLOGIC		
Inhalant (Nasal) Allergies	Yes	No
Immunologic Disorders	Yes	No
PSYCHIATRIC		
Anxiety	Yes	No
Depression	Yes	No
Other Psychiatric Disorder	Yes	No
NEUROLOGICAL		
Fainting Spells or “Blacking Out”	Yes	No
Seizures	Yes	No
Coordination in Arm and/or Legs	Yes	No
Stroke	Yes	No
Balance Problem	Yes	No
Headaches	Yes	No

The above information is accurate to the best of my knowledge.

_____

Patient Signature Date

I have reviewed the above information with the patient.

_____

David A Halsey, MD Date