Greenville Orthopedic

PATIENT HEALTH HISTORY

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible. ***Please fill out every item.*** It is important for the doctor to know you have carefully reviewed every area of this form.

Patient's Last Name: _____ First: _____ Middle: _____

Sex: ☐ Male ☐ Female **Race: _____ Ethnicity: _____ Date of Birth: _____**

Preferred Language: _____ Name of Primary Care Physician: _____

Pharmacy Preference (please include location): _____ Pharmacy Phone: _____

REASON FOR TODAY'S VISIT: _____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

Name of Medication	Dosage	How Often Taken

ARE YOU ALLERGIC TO ANY MEDICATION? ☐ Yes ☐ No *If yes, please list below:*

Name of Medication	Type of Reaction

SURGERIES AND HOSPITALIZATIONS:

Surgery	Date

Have you ever had any problems with anesthesia (being numbed or put to sleep)? ____ Yes ____ No
If yes, please list type of problems: _____
_____

Have you ever been hospitalized for non-surgical reasons? ____ Yes ____ No
If yes, please list reasons for hospitalizations: _____
CURRENT OR MOST RECENT OCCUPATION: _____