Do not write, stamp, punch holes or affix a sticker in this area.

Direction of Feed

Patient History

Please answer every question

To reproduce, follow the printing instructions.
Do not fold this form.

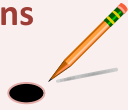
PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH
Month Day Year

Marking Instructions

Please use a #2 pencil.
Fill in the complete oval as shown...



SOCIAL HISTORY

TOBACCO USE

What is your smoking status?
- current (every day)
- current (some days)
- previous
- never

At what age did you begin smoking?
10 20 30 40 50 60 70 80 90
1 2 3 4 5 6 7 8 9

EXAMPLE
If you started smoking at the age of 21, you would fill in the ovals like this:
10 20 30
1 2 3

If you quit smoking, at what age did you quit?
10 20 30 40 50 60 70 80 90
1 2 3 4 5 6 7 8 9

How many cigarettes do you currently smoke (or did you previously smoke) **per day?**
10 20 30 40 50 60 70 80 90
1 2 3 4 5 6 7 8 9

How many cigars or pipes do you smoke per week?
- none
- 3-5
- <1
- 6-9
- 1-2
- 10+

How many cans of smokeless / chewing tobacco do you use per week?
- none
- 1
- <1/2
- 2
- 1/2
- 3+

Are you exposed to passive (second hand) **smoke?**
- yes
- no

ALCOHOL USE

Do you drink alcohol?
- no
- yes, 1-2 times per week
- yes, 1-2 times per month
- yes, 1-2 times per year

DRUG USE

Do you have a history of substance abuse?
- no
- yes

If yes, which substances?
- meth
- cocaine
- heroin
- marijuana
- prescriptions not prescribed to me
- prescription medications
- other

EXERCISE

How often do you exercise?
- daily
- weekly
- monthly
- rarely
- never

If you do exercise, which type(s)?
- aerobics
- swimming
- running
- walking
- bicycling
- other

SAMPLE

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Patient History

Please answer every question

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SOCIAL HISTORY

OTHER

What is your marital status?
- single
- married
- partnered
- separated
- divorced
- widowed

What is your employment status?
- part-time
- full-time
- not employed
- active duty
- self employed
- retired
- disabled

How many children do you have?
0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11+

What is your student status?
- full-time
- part-time
- not a student

Do you live alone?
- no
- yes

Are you on a special diet?
- no
- yes

PAST MEDICAL HISTORY

- Heart Disease
- High Blood Pressure
- Cancer
- Arthritis
- Polio
- Diabetes
- Epilepsy
- HIV
- Hepatitis
- Tuberculosis
- Anesthesia Problems
- Other
- **NONE**

SURGICAL HISTORY

- Arthroscopic Knee Surgery
- Open Knee Surgery
- Arthroscopic Shoulder Surgery
- Open Shoulder Surgery
- Other Orthopaedic Surgery

I HAVE HAD NO SURGERIES

FAMILY HISTORY

Please indicate which family member(s) have had these conditions:

FAMILY HISTORY UNKNOWN

	Father	Mother	Brother	Sister	Son	Daughter
Diabetes						
Heart Disease						
Arthritis						
High Blood Pressure						
Difficulty with Anesthesia						
No Significant Medical History						

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