HEALTH HISTORY FORM

Patient Name:
Birthdate: ____________________
Health Care #: ________________

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Please complete this form and give it to your surgeon's team at your appointment.

*** Please bring all your current medications, vitamins, supplements, etc. in their original containers to your appointment ***

Which joint(s) are you coming to see us for? □ Hip □ Knee □ Other: ______________________
Which side bothers you more? □ Right □ Left □ Both
Have you had any previous injuries to the affected joint(s)? Please detail:

Select which walking aids you currently use: □ None □Cane/Stick □ Walker □ Wheelchair

How long can you walk without stopping?
□ <2 blocks (5 min) □ 2-5 blocks (5-10 min) □ 0.5-1 km (10-20 min) □ >2km (>30 min)

Does your joint pain wake you from sleep? □ Never □ Occasionally □ Often □ Almost always

What activities does your hip/knee keep you from doing? (eg. Recreation, stairs, kneeling)

Please select what options you have tried for managing your hip/knee pain:
□ Physiotherapy □ Bracing
□ Anti-inflammatories Details: ____
□ Other Pain Medication Details: ____
□ Injections Details: ____
□ Other: ____

Allergies: Please be specific with your allergic reactions

Allergy	Reaction	Allergy	Reaction

Do you have a metal allergy? □ No □ Yes Do you have a latex allergy? □ No □ Yes

Height: _______________ Current Weight: _______________

Past Surgical History: If you are unsure about a date or location please estimate/guess

What	When	Location/Name of Surgeon

Previous Tests: If you are unsure about a date please estimate/guess

Test	Date	Location
□ Exercise stress test (treadmill)		
□ Thallium (nuclear medicine)		
□ Heart catheterization (angiogram)		
□ ECHO (heart ultrasound)		
□ Holter monitor		
□ ECG		
□ Pulmonary function		
□ Chest x-ray		
□ Sleep Study		

Social History

Tobacco Use
□ Never □ Quit - Date: ____________ # of years: _______ Amount used? _____ /per day □ Yes: Cigarettes: ___ Cigars: ___ Vape: ___ Chew/Spit: ___ # of years: ______ Amount used? ______ /per day
Alcohol Use
Do you drink alcohol? □ No □ Yes # of drinks/week: ______ □ Beer □ Wine □ Liquor
Drug Use
Have you used marijuana or recreational drugs within the last two years? □ No □ Yes
Language Spoken
□ English □ Other________________
Personal Directive
Do you have a personal directive? □ No □ Yes If yes, please bring a copy to your next appointment

Family Medical History – Parents or Siblings (e.g. cancer, stroke, heart disease, diabetes, etc)

Who	What

Anesthetic History: Please mark a check ✓ if it applies

___ Previous General anesthetic ___ Previous Spinal anesthetic ___ Previous Local Anesthetic	___ Complications from anesthetic, either yourself or a family member ___ History of nausea/vomiting after surgery

Specialist Assessments in the last FIVE years

Doctor	Name	Date (YYYY-MM-DD)	Location
□ Cardiologist			
□ Neurologist			
□ Pulmonologist			
□			
□			
□			

Support after Surgery

If you proceed to surgery, who will help you during your preparation and recovery from surgery? **Name:**_______________________ **Relationship:**____________________ **Phone:** _______________________	
Do you live alone?	□ No □ Yes
Who will be your caregiver after surgery?	
How long will the caregiver stay after surgery?	

Fall Risk Assessment

Do you have a history of falls?	□ No □ Yes
When did you fall?	Date(s) :
Did you have any injuries as a result of a fall?	□ No □ Yes Details:
Do you get dizzy or light-headed when you stand up or when walking?	□ No □ Yes

Review of Symptoms: Please mark a check ✓ for any symptoms you have currently or have had in the past. Please mark any other concerns in the other field below.

Neurological (Head)	Respiratory (Lungs)	Kidney
___ Problems moving or feeling any part of your body	___ Asthma	___ Kidney Problems
___ Stroke	___ Frequent Bronchitis	
___ Convulsions/Seizures	___ Emphysema	**Urinary**
___ Parkinson's	___ Pneumonia	___ Prostate Problems
___ Multiple Sclerosis	___ Chronic obstructive	___ Previous catheterization
___ Polio	If yes, do you use oxygen at home? □ No □ Yes	___ Postmenopausal
___ Fainting/Blackouts	___ Pulmonary disease (COPD)	___ Seen a Urologist
___ Fibromyalgia	___ Shortness of breath	___ Frequent bladder infection
___ Memory Loss	___ Tuberculosis	___ Difficulty controlling urine
___ Dementia	___ Sleep Apnea ____ CPAP	___ Incontinence
		___ Waking up to urinate
Mental Health Disorders	OR	**Liver**
___ Depression	___ Snores at night	___ Hepatitis
___ Bipolar	___ Stop breathing at night	___ Liver Problems
___ PTSD	___Tired from poor sleep	Details: ___________________
___ Schizophrenia	**Gastrointestinal (Stomach)**	**Endocrine**
___ ADHD	___ Stomach Problems	___ Steroid use (Cortisone/Prednisone)
Cardio/Vascular (Heart)	___ Acid reflux/Heartburn	
___ Atrial Fibrillation	___Constipation ___ Diarrhea	___ Diabetes
___ Pacemaker	___ Irritable bowel	□ Type 1 □ Type 2
___ Low blood pressure	___ Recent weight gain/loss	Insulin? □ No □ Yes
___ High blood pressure	___ Crohn's	**Musculoskeletal**
___ Heart Attack	___ Colitis	___ Back Pain
___ Chest Pain	**Skin**	___ Osteoarthritis
___ Blood clot to lung or leg	___ Open sores or rashes	___ Osteoporosis (thin bones)
___ Vascular disease	___ Piercing	___ Rheumatoid
Blood	___Tattoos	___ Inflammatory Arthritis
___ HIV / AIDS	**Cancer**	___ Jaw / Neck Problems
___ Reaction to blood transfusion	___ Self	___ Cortisone injection
___ Blood disorder	Date(s): _________________	When_____ Where______
___ Low blood count/Anemia	Treatment: ______________	___ Chronic pain
___ Jehovah Witness	___ Family	___ Joint Infection

Other		
Have you ever become confused or had memory problems after an anesthetic?	□ No □ Yes	
Do you experience heart or breathing problems after walking 4 blocks on level ground?	□ No □ Yes	
Do you experience heart or breathing problems after you climb 2 flights of stairs?	□ No □ Yes	
Have you been treated for an antibiotic resistant infection?	□ No □ Yes	
Have you had recent contact with any communicable disease?	□ No □ Yes	
Have you experienced recent weight loss without trying?	□ No □ Yes	How much? ___ lbs Decreased appetite? □ No □ Yes
Do you have vision problems?	□ No □ Yes	□ Aids______________
Do you have hearing problems?	□ No □ Yes	□ Aids______________
What is your dental history?	□ Full Dentures if no, date of last dental exam___________ □ Caps/Crowns □ Bridgework	
Have you ever experienced motion sickness?	□ No □ Yes	
Did you get your flu vaccine this year?	□ No □ Yes	When? ___________
Have you ever had a pneumonia vaccine?	□ No □ Yes	When? ___________
Did you get your COVID-19 vaccine this year?	□ No □ Yes	When? ___________

Medications:

What Pharmacy do you use?: ___________________________
Location: ___________________________ Phone Number: ___________________

PLEASE WRITE **ALL** MEDICATIONS, VITAMINS AND SUPPLEMENTS YOU TAKE BELOW.
PLEASE ALSO BRING MEDICATIONS TO YOUR FIRST APPOINTMENT IN THEIR ORIGINAL CONTAINERS.

NAME	DOSE	TIME OF DAY TAKEN