35 Hospital Road
Blairsville, GA 30512-3139
706-439-6858

UNION GENERAL ORTHOPEDICS

AFFILIATE OF: UNION GENERAL HOSPITAL, INC.

PATIENT HISTORY FORM

Last Name: _____ First Name: _____ M.I. _____

Address: _____ City: _____ State: _____

Zip: _____ Home Phone: (____) _____ Cell Phone: (____) _____

Preferred Pharmacy: _____ Pharmacy Phone No.: (____) _____

Please list all medications you are currently taking including over-the-counter medications.

Medication	Dosage	Frequency

Please indicate any drug allergies.

NAME OF MEDICATION	REACTION

FAMILY HISTORY

Please indicate any health conditions that apply to **Mother, Father, Siblings, and/or Children**

CONDITION	Who?	DESCRIPTION
Heart Disease		
Diabetes		
Cancer		
Other:		

SOCIAL HISTORY

Marital Status: (Single) (Married) (Divorced) (Widowed) (Other)

Highest Level of Education Completed: (Please Circle one) High School College Other

Do you work? (Yes) (No) Occupation:_____

Disabled? (Yes) (No) Why? _____

Do you Exercise? Yes No How Often: _____

What are your Hobbies? _____

Do you live alone? Yes No

Use of Alcohol: Never Rarely Moderate Daily

Smoking Status: (Never) (Former) (Current Everyday) (Current Somedays) Number of Years: _____

Chewing Tobacco Use: (None) (1x daily) (2-4x daily) (5+ daily)

Use of Illicit Drugs: Yes No Type/frequency:_____

SURGICAL HISTORY

SURGERY TYPE	DATE

PAST MEDICAL HISTORY

Previous treatment to area of interest today: _____

Orthopedic problems or history of joint replacement: _____

_____

CONDITION	YES	NO	DESCRIBE
Arthritis			
Blood Disease			
Breast Problems			
Cancer			
Circulation Problems			
Diabetes			
Ear or Hearing Problems			

GI Problems			
Headaches			
Heart Disease			
High Blood Pressure			
High Cholesterol			
Kidney or Bladder Disease			
Liver Disease			
Lung Disease/Breathing Problems			
Mental Issues/Illness			
Muscle/Joint/Bone Problems			
Skin Disease/Problems			
Sleep Apnea			
Stroke			
Thyroid Problems			
Vision or Eye Problems			
Other			

REVIEW OF SYMPTOMS

CONDITION	YES	NO	CONDITION	YES	NO
CONSTITUTIONAL			**GU**		
Weight Loss			Difficulty Urinating		
Weight Gain			Loss of Control/Leaking		
Fatigue			Increased Frequency		
Trouble Sleeping			Inability to Empty Bladder		
EYES			**MUSCULOSKELETAL**		
Changes in Vision			Back Pain		
ENT			Joint Pain		
Nosebleeds			Trouble Walking		
Sinus Problems			Neck Pain		
Sore Throat			Limited Range of Motion		
Bleeding/Sore Gums			**SKIN**		
Dry Mouth			Rashes		
Snoring			Growths/Lesions		
CARDIOVASCULAR			Trouble Healing		
Chest Pain			Change in Color		
Arrhythmia/Palpitations			**NEURO**		
Ankle Swelling			Frequent/Severe Headaches		
RESPIRATORY			Weakness		
Shortness of Breath			Dizziness		
Coughing			Numbness		

Wheezing			**PSYCH**		
GI			Depression		
Abdominal Pain			Anxiety		
Nausea			Memory Loss		
Vomiting			**ENDROCRINE**		
Black/Tarry Stools			Heat or Cold Intolerance		
Diarrhea			Excessive Thirst		
Reflux/Heartburn			**HEMATOLOGICAL/LYMPH**		
			Abnormal Bleeding		
			Bruise Easily		

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____