

KANSAS JOINT AND SPINE INSTITUTE, CHARTERED

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Wichita, KS 67226

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PATIENT HISTORY

PATIENT NAME (LAST)	(FIRST)	(MIDDLE)	AGE	HEIGHT	WEIGHT

PATIENT MEDICAL HISTORY

Alcohol consumption <input type="checkbox"/> Yes <input type="checkbox"/> No How much _____ Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No Bladder disorder <input type="checkbox"/> Yes <input type="checkbox"/> No Bleeding disorder <input type="checkbox"/> Yes <input type="checkbox"/> No Bowel disorder <input type="checkbox"/> Yes <input type="checkbox"/> No Bronchitis <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No Convulsions <input type="checkbox"/> Yes <input type="checkbox"/> No Currently pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No	CVA / Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No Depression <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No Dialysis <input type="checkbox"/> Yes <input type="checkbox"/> No Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No Fainting spells <input type="checkbox"/> Yes <input type="checkbox"/> No Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No Had a cold recently <input type="checkbox"/> Yes <input type="checkbox"/> No Hearing problems <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis (B or C) <input type="checkbox"/> Yes <input type="checkbox"/> No HIV / AIDS exposure <input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney problems <input type="checkbox"/> Yes <input type="checkbox"/> No Latex sensitive <input type="checkbox"/> Yes <input type="checkbox"/> No Pneumonia <input type="checkbox"/> Yes <input type="checkbox"/> No Sinusitis <input type="checkbox"/> Yes <input type="checkbox"/> No Sickle Cell <input type="checkbox"/> Yes <input type="checkbox"/> No Smoking <input type="checkbox"/> Yes <input type="checkbox"/> No How much _____ Stomach disorders <input type="checkbox"/> Yes <input type="checkbox"/> No Thyroid problems <input type="checkbox"/> Yes <input type="checkbox"/> No Tremors / Parkinson's <input type="checkbox"/> Yes <input type="checkbox"/> No
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Please list all current medications: _____

Please list any medications that you have a history of allergic reaction to: (list what your reaction was): _____

Please list all previous surgeries: _____

CARDIOVASCULAR HISTORY

Do you have high blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have palpitations <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have fast heartbeats <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have a heart murmur <input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from chest pain <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had a heart attack <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have any heart disease <input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer irregular heartbeats <input type="checkbox"/> Yes <input type="checkbox"/> No Do you suffer from angina <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have a cardiac pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had a stroke <input type="checkbox"/> Yes <input type="checkbox"/> No
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FAMILY MEDICAL HISTORY

Please list any family medical history: (living or deceased) What family member?

Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No	Relation: _____	<input type="checkbox"/> Living	<input type="checkbox"/> Deceased
Heart disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Relation: _____	<input type="checkbox"/> Living	<input type="checkbox"/> Deceased
High blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	Relation: _____	<input type="checkbox"/> Living	<input type="checkbox"/> Deceased
Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	Relation: _____	<input type="checkbox"/> Living	<input type="checkbox"/> Deceased
Depression/Mental disorders <input type="checkbox"/> Yes <input type="checkbox"/> No	Relation: _____	<input type="checkbox"/> Living	<input type="checkbox"/> Deceased
Other _____	Relation: _____	<input type="checkbox"/> Living	<input type="checkbox"/> Deceased
Other _____	Relation: _____	<input type="checkbox"/> Living	<input type="checkbox"/> Deceased
Other _____	Relation: _____	<input type="checkbox"/> Living	<input type="checkbox"/> Deceased
Other _____	Relation: _____	<input type="checkbox"/> Living	<input type="checkbox"/> Deceased

PATIENT SIGNATURE	DATE

Blood Pressure: _____ Pulse: _____ Temp: _____