JAN LEO, MD
ORTHOPEDIC SURGERY
SPECIALIZING IN UPPER EXTREMITIES

NAME:_____ **AGE**_____ **DATE OF BIRTH:**_____

OCCUPATION:_____

What hand do you write with? Right____ **Left**_____ **Height**_____ **Weight**_____

HOW WOULD YOU RATE YOUR HEALTH? EXCELLENT___ **GOOD**___ **FAIR**___ **POOR**___

Do you smoke? YES NO QUIT **If yes, how many cigarettes per day?**_____

Do drink alchol? YES NO **If yes, how much?**____ **how often?**_____

Are you at risk for HIV/AIDS? Yes NO Have you been tested? Yes No Results?____

Medication Allergies? YES NO Please List Allergies:_____

Are you allergic to latex? YES NO Adhesive? YES NO Have you been tested?_____

What medications do you take? Please list all meds including herbals, vitamins and over the counter.

Has anyone in your family had a heart attack before age 55? Yes No

Have you ever had a bad reaction to anesthesia? Yes No

Do you bruise or bleed easily? Yes No

Please list all hospitalizations and surgeries:_____

On the back of this form are questions about your health and medical history. This form must be updated yearly. Please complete it as accurately as possible, and be sure to sign and date the form when it is complete. All information will be kept confidential. Thank You.

HEALTH HISTORY FORM

YES	NO	DISEASE	YES	NO	DISEASE
		Irregular Heart Beat			Prostate Problems
		Congestive Heart Failure			Liver Disease, Type:
		Heart Attack			Hepatitis? When?
		Stroke			Gallstones
		Heart Murmur			Arthritis, Type:
		Pace Maker (chest pain – angina?)			Rheumatoid
		High Blood Pressure			Osteoarthritis
		High Cholesterol			Fibromyalgia
		Diabetes/High Blood Sugar			Gout
		Asthma			Thyroid Problems
		Emphysema/Chronic Bronchitis			Cancer, Type:
		Sleep Apnea			Epilepsy/Seizures
		Do you wear oxygen?			Rheumatic Fever
		Tuberculosis			Muscle Weakness
		Blood Clot in Leg			Anemia/Low Blood
		Blood Clot in Lung			Skin Disease, Type:
		Bleeding Problems, Type:			Glaucoma
		Blood Transfusion			Hearing aid
		Ulcers in Bowel/Stomach			Claustrophobia
		Bleeding from Bowels			Depression
		Kidney Disease, Type:			Anxiety
		Kidney Stones			Other:

When was your most recent physical?_____ **Labs?**_____ **EKG?**_____

With which provider?_____

Please list all treating physician names and phone numbers:

_____

_____

_____

Patient Signature:_____ **Date:**_____