# PATIENT HISTORY FORM

## Patient Information

Date ----------

Name Surname ---------- Date of Birth ----------

Phone ---------- E-Mail ----------

Height ---------- Weight ----------

Nationality ---------- Languages ----------

Address ----------

---

## Details of Confidant

Name Surname ---------- Date of Birth ----------

Phone ---------- E-Mail ----------

Nationality ---------- Languages ----------

Address ----------

---

## Condition / Disease

☐ Osteoarthritis ☐ Rheumatoid Arthritis ☐ Other Type of Arthritis

☐ Traumatic Injury : ----------

☐ Other ----------

**Condition/Disease Exists Since** ----------

## Pre-existing Diseases

---

Next
New Steps

## Medical Information

**Do you have allergies to medications, latex, or food?**

☐ NO ☐ YES: ----------

**Do you have history of smoking?**

☐ NO ☐ YES: ----------

**Do you now have, or have you ever had, the following medical problems?**

- ☐ Heart Attack/Heart Failure
- ☐ Chronic Kidney Disease
- ☐ Chest pain, pressure, squeezing
- ☐ Arrhytmia / Palpitations
- ☐ Cold or Flu within last 2 weeks
- ☐ Liver Disease: Hepatitis/Jaundice
- ☐ Blood Disorders / Diseases
- ☐ Lupus (SLE) / Multiple Sclerosis
- ☐ Tuberculosis / Pneumonia
- ☐ Diabetes
- ☐ High/Low Blood Pressure
- ☐ High Cholesterol
- ☐ Stroke / Mini Stroke
- ☐ Asthma
- ☐ Prostate Disorder
- ☐ Seizures / Epilepsy
- ☐ Anemia
- ☐ COPD

**Do/did any of your family have any of the following?**

- ☐ Rheumatoid Arthritis
- ☐ Other Joint problems
- ☐ Bleeding problems
- ☐ Anesthesia problems
- ☐ Mental Illness
- ☐ Heart Attack
- ☐ Cancer
- ☐ Diabetes
- ☐ Stroke
- ☐ Thyroid Disease

## Other severe accidents or diseases / NOTES

Next
New Steps

## Medical Information

### Please write your symptoms (pain, swelling and limitations)

### Please list every operation that you have had under anesthesia

### Please list all of your current medications

### Reviewer

| | |
|---|---|
| Name | |
| Surname | |
| Result (Y/N) | |
| Estimated Stay | |

### Notes

Next
New Steps