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Director of Joint Replacement Surgery

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CELEBRATION ORTHOPAEDIC & SPORTS MEDICINE INSTITUTE

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BRAD HOMAN, DO

Director of Sports Medicine at Celebration Health

STEPHEN A. KNYCH, MD, MBA

Joint Replacement, Sports Medicine and Foot & Ankle

Clinical History – Please Complete Front & Back

Form with fields for Name, Age, Marital Status, Date, Occupation, Employer, Birthplace, Education, Date Last Physical, Family Doctor, Medications, Physicians, Allergies, Health, Smoking, Drinking, Alcohol, IV drugs, HIV exposure.

Note: This is a confidential record of your medical history and will be kept in this office. Information contained herewith will not be released to anyone unless you authorize us to do so.

Medical History: Have you ever had any of the following? Please circle YES or NO for all questions.

Medical History grid with columns for Childhood Diseases, Cardiac Diseases, Infections, Metabolic Diseases, GI Diseases, Blood Disorders, Pulmonary Diseases, Urologic Diseases, Arthritis, CNS Diseases, Cancer, and Miscellaneous.

### Surgical History

Have you had previous surgery?  Yes  No

If yes, what type?	Year	Type	Year
1. _____	_____	3. _____	_____
2. _____	_____	4. _____	_____
3. _____	_____	5. _____	_____

### Hospitalizations

Have you ever been hospitalized for any illness other than surgery or childbirth?  Yes  No

If yes, please list: Diagnosis	Year	Diagnosis	Year
1. _____	_____	3. _____	_____
2. _____	_____	4. _____	_____

### Review of Systems (Please check Yes or No for all categories)

<p><b><u>Musculoskeletal</u></b></p> <p>Fracture/Broken Bone    Yes    No Body Part: _____</p> <p>Sprains    Yes    No Body Part: _____</p> <p>Dislocation    Yes    No Body Part: _____</p> <p>Back Injury    Yes    No</p> <p>Concussion/Head Injury</p> <p><b><u>Constitutional</u></b></p> <p>Night Sweats    Yes    No</p> <p>Abnormal Thirst    Yes    No</p>	<p><b><u>HEENT</u></b></p> <p>Impaired Sight    Yes    No</p> <p>Headaches    Yes    No</p> <p><b><u>Skin</u></b></p> <p>Frequent Rashes    Yes    No</p> <p>Psoriasis    Yes    No</p> <p><b><u>Immunological/Lymphatics</u></b></p> <p>Frequent Infections    Yes    No</p> <p>Swelling of Feet    Yes    No</p> <p><b><u>Cardiological</u></b></p> <p>Dizziness    Yes    No</p> <p>Fainting    Yes    No</p> <p>Chest Pain    Yes    No</p>	<p><b><u>Respiratory</u></b></p> <p>Cough    Yes    No</p> <p>Shortness of Breath    Yes    No</p> <p><b><u>Gastroenterological</u></b></p> <p>Spitting Up Blood    Yes    No</p> <p>Constipation    Yes    No</p> <p>Diarrhea    Yes    No</p> <p>Heartburn    Yes    No</p> <p>Rectal Bleeding    Yes    No</p> <p>Black Stools    Yes    No</p> <p><b><u>Genitourinary</u></b></p> <p>Frequent Urination    Yes    No</p> <p>Painful Urination    Yes    No</p>	<p><b><u>Neurological</u></b></p> <p>Weakness    Yes    No</p> <p>Temporary Paralysis    Yes    No</p> <p>Temporary Loss of Sight    Yes    No</p> <p><b><u>Psychiatric</u></b></p> <p>Depression    Yes    No</p> <p>Schizophrenia    Yes    No</p> <p>Hospitalization for Psychiatric Illness    Yes    No</p> <p>Bipolar Disorder    Yes    No</p> <p>Drug Abuse    Yes    No</p> <p>Alcohol Abuse    Yes    No</p>
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### OB/GYN (Women Only)

Is there any chance you could be pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure	Taking estrogen? <input type="checkbox"/> Yes <input type="checkbox"/> No
Any history of abnormal menstrual cycle? <input type="checkbox"/> Yes <input type="checkbox"/> No	Menopause? <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, what year? _____

### Family History

	If Living		If Deceased	
	Age	Health	Age At Death	Cause
Father				
Mother				
Brother/Sister				
Brother/Sister				
Brother/Sister				
Brother/Sister				
<b>Has any blood relative ever had</b>				
Heart Problems	Yes	No	Who? _____	Stroke    Yes    No    Who? _____
Diabetes	Yes	No	Who? _____	Epilepsy    Yes    No    Who? _____
High Blood Pressure	Yes	No	Who? _____	Tuberculosis    Yes    No    Who? _____
				Cancer    Yes    No    Who? _____