THE CHRIST HOSPITAL ORTHOPAEDIC ASSOCIATES

Cincinnati Bone & Joint Institute

HEALTH HISTORY ***(pg 1)***

Patient Demographics:

Patient Name: _____
First MI Last

SS#: _____ Birth date: _____ Sex: ***Male*** ***Female***

Address: _____ _____ _____
Street Address City/State Zip Code

Home #_____ Cell #_____ Work #_____
(Include area code) (Include area code) (Include area code)

Marital Status: ***M*** ***S*** ***D*** ***W*** Patient's: height _____ / weight _____

E-Mail Address: _____

* * * *

Guardian Information (If Patient is a Minor):

Name: _____ Relationship to Patient_____

SS#: _____ Birth date: _____ Sex: ***Male*** ***Female***

Address: _____ _____ _____
Street Address City/State Zip Code

Home #_____ Cell #_____ Work #_____
(Include area code) (Include area code) (Include area code)

Please list any **RX or OTC Medications** that you are currently taking:			
MEDICATION	**DOSE**	**MEDICATION**	**DOSE**
1)		6)	
2)		7)	
3)		8)	
4)		9)	
5)		10)	

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS OR SUBSTANCES? **Yes** **No**

If so, please list: _____

ALLERGY TO LATEX? **Yes** **No**

Social History

Alcohol intake : **Yes** **No** Drinks per week: _____

Smoking: **Yes** **No** Packs per day: _____ Years: _____

Tobacco: **Yes** **No** Years: _____

Illicit Drugs: **Yes** **No** Type: _____