

**THE CHRIST HOSPITAL ORTHOPAEDIC ASSOCIATES**  
**Cincinnati Bone & Joint Institute**  
**HEALTH HISTORY (pg 2)**

**Medical History:**

**Name:** \_\_\_\_\_

Check if you have had any of these **medical problems** in the PAST:

MAJOR ILLNESS	YES	NO	MAJOR ILLNESS	YES	NO
Anemia or Other Blood Disease			Lung Disease		
Anxiety			Neurological Disease		
Arthritis/Osteo			Neuropathy		
Arthritis/Rheumatoid			Numbness or Tingling		
Asthma			Osteoporosis		
Bleeding Disorder			Pacemaker		
Blood Clots			Paralysis		
Cancer: Type _____			Peripheral Vascular Disease		
Depression			Pneumonia		
Diabetes - Insulin / Non			Polio		
Emphysema			Psychiatric Illness		
Fibromyalgia			Pulmonary Embolism		
Frequent/Easy Bruising			Rash		
Glaucoma			Reflux		
Heart Disease			Seizures		
Hepatitis B			Skin Ulcer		
Hepatitis C			Steroid Use		
High Blood Pressure			Stroke		
High Cholesterol			Thyroid Disease		
HIV / AIDS			Tuberculosis - TB		
Irregular/Rapid Heartbeat			Ulcer or Stomach Disease		
Kidney or Bladder Disease			Urinary Infections		
Liver Disease			Wound Healing Problems		
			OTHER:		

Please list any **operations/surgeries** you have had:

SURGERY/REASON	YEAR	SURGERY/REASON	YEAR
1)		5)	
2)		6)	
3)		7)	
4)		8)	