H. Michael Mynatt, M.D.
Total Joint Reconstruction
Patient Health History Questionnaire

Name: ______________________________
Last   First   Middle

Date of Birth: ______________________ **Gender:** F M
Month Day Year

Height: ______________ **Weight:** ______________

Briefly describe any problems/symptoms you are currently experiencing:

____
____
____
____

PAST HISTORY

Please list all surgeries and serious accidents:

Surgery/Accident	Date

Please check if you have had any of the following:

Illness	Date	Illness	Date
☐ Heart trouble	____/____/____	☐ Ulcer	____/____/____
☐ High blood pressure	____/____/____	☐ Heart burn/Acid reflux	____/____/____
☐ Stroke or paralysis	____/____/____	☐ Diabetes	____/____/____
☐ Migraine	____/____/____	☐ Blood clots	____/____/____
☐ Seizures	____/____/____	☐ Elevated cholesterol	____/____/____
☐ Asthma	____/____/____	☐ Blood disorders	____/____/____
☐ Emphysema	____/____/____	☐ Eye problems	____/____/____
☐ Tuberculosis	____/____/____	☐ Ear problems	____/____/____
☐ Pneumonia	____/____/____	☐ Mental illness	____/____/____
☐ Lung disease	____/____/____	☐ Venereal disease	____/____/____
☐ Thyroid Disease	____/____/____	☐ Arthritis	____/____/____
☐ Hepatitis	____/____/____	☐ Osteoporosis	____/____/____
☐ Liver Disease	____/____/____	☐ Bone disease	____/____/____
☐ Kidney stones	____/____/____	☐ Joint Problems	____/____/____
☐ Kidney disease	____/____/____	☐ Back problems	____/____/____
☐ Gall stones	____/____/____		

☐ Cancer. If so, what type: ______________________________

☐ Other: ______________________________

H. Michael Mynatt, M.D.

Total Joint Reconstruction

Patient Health History Questionnaire

ALLERGIES

Have you had hives, skin rash, breathing problems or other allergic reactions due to medications or foods? ☐ No ☐ Yes – list below:

Name of Medication or Food	Describe Allergic Reaction

MEDICATIONS

Are you currently taking any prescription and / or non-prescription medications including vitamins, nutritional supplements, oral contraceptives, pain relievers, diuretics, laxatives, and cold medication? ☐ No ☐ Yes

If yes, list medications:

Name of Medication	Dose (Strength)	How Often Taken (e.g. 1 per day)

REVIEW OF SYSTEMS

Do you have any of the following symptoms on a regular basis?

☐ Weight loss	☐ Earache	☐ Bowel Problems	☐ Neck pain
☐ Weight gain	☐ Sore throat	☐ Diarrhea	☐ Back pain
☐ Fever	☐ Chest pain	☐ Urinary bleeding	☐ Back stiffness
☐ Chills	☐ Cough	☐ Urinary pain	☐ Joint pain
☐ Headache	☐ Short of breath	☐ Bladder problems	☐ Joint stiffness
☐ Dizziness	☐ Wheezing	☐ Pelvic pain	☐ Joint swelling
☐ Passing out/Fainting	☐ Heartburn	☐Numbness/tingling	☐ Muscle pain
☐ Nausea/Vomiting	☐ Black colored stool	☐ Weakness	☐ Muscle stiffness
☐ Double vision	☐ Bleeding from stool	☐ Fatigue	☐ Difficulty moving an arm/leg
☐ Blurred vision	☐ Abdominal pain	☐ Swelling	

SOCIAL HISTORY

How often do you exercise? ☐ Light ☐ Moderate ☐ Intense

Describe your exercise pattern: ______________________________

Do you use tobacco? ☐ No ☐ Yes. If yes, how much per week: ______________

Do you drink alcohol? ☐ No ☐ Yes. If yes, how many drinks per week: ______________

If yes, what type of alcohol (beer, wine, liquor): ______________

H. Michael Mynatt, M.D.

Total Joint Reconstruction

Patient Health History Questionnaire

HEALTHCARE PROVIDER INFORMATION

Do you have a Primary Care Physician?

☐ No ☐ Yes – write name, title, address & phone below:

Name / Title:	
(Area Code) Phone:	
Address:	
City / State / Zip:	

Do you want a summary of your visits sent to this person? ☐ No ☐ Yes

Did another physician or healthcare provider recommend or arrange this visit for you?

☐ No ☐ Yes – write name, title, address & phone below:

Name / Title:	
(Area Code) Phone:	
Address:	
City / State / Zip:	

Do you want a summary of your visits sent to this person? ☐ No ☐ Yes

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize the Joint Replacement Institute of SVMC , its employees or agents, to forward my medical information (including psychiatric and drug abuse diagnosis and treatment information) to those individuals listed above, and other healthcare providers who may be responsible for my continuing medical care.

Print Name:	
Signature:	
Date:	