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*Health History Questionnaire*

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

*Please mark if you have a history of any of the following:*

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Convulsions           | <input type="checkbox"/> Cancer: _____             |
| <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Stroke                | <input type="checkbox"/> Anxiety                   |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Paralysis             | <input type="checkbox"/> Depression                |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Shortness of Breath   | <input type="checkbox"/> Seizures                  |
| <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Heart Palpitations    | <input type="checkbox"/> Sleep Apnea               |
| <input type="checkbox"/> HIV/AIDS            | <input type="checkbox"/> Heart Murmurs         | <input type="checkbox"/> Smoke                     |
| <input type="checkbox"/> Clotting Disorders  | <input type="checkbox"/> Tuberculosis          | <input type="checkbox"/> Excessive Alcohol Use     |
| <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Women - Pregnant/ Nursing |

Do you have any other health issues or concerns?    Yes    No

Please list your concerns: \_\_\_\_\_

\_\_\_\_\_

Do you have any allergies?                      Yes    No

Please list all allergies & reactions: \_\_\_\_\_

\_\_\_\_\_

Have you had prior surgery?                      Yes    No

Please list ALL surgeries: \_\_\_\_\_

\_\_\_\_\_

Do you take any medication?                      Yes    No

Please list ALL medications including over the counter: \_\_\_\_\_

\_\_\_\_\_

Please describe why you are here today, and your symptoms: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_