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ORTHOPEDIC AND FRACTURE SURGERY  
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**HEALTH HISTORY FORM**

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Chief Complaint – Why you seeing the doctor today:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

1. Current problem is the result of a/an - Please circle all that apply:

Car Accident    Work Accident  
Accident

Other, please specify:  
\_\_\_\_\_  
\_\_\_\_\_

Medication	Dose	Reason for Medication	Side Effects
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies:  
\_\_\_\_\_

Are all immunizations current?            Yes    No

If no, which are due?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Review of Symptoms

Please describe any yes answers.

Are you currently having any trouble with your:

Eyes	Yes	No
Ears, Nose, Throat	Yes	No
Lungs, Breathing	Yes	No
Digestion	Yes	No
Bowel Movements	Yes	No
Bladder	Yes	No
Diabetes	Yes	No
High Blood Pressure	Yes	No
Bleeding Problems	Yes	No
Balance Problems	Yes	No
Numbness/Tingling	Yes	No
Blackout/Fainting	Yes	No
Psychological Problems	Yes	No
AIDS	Yes	No
Cancer	Yes	No
Arthritis	Yes	No
Polio	Yes	No
TB	Yes	No
Epilepsy	Yes	No

### Past Medical History

Surgeries/Hospitalizations	Year	Complications

Have you ever had general anesthesia?                      Yes      No  
Have you had any problems with anesthesia?              Yes      No  
Please describe any problems:

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### Family History

Member	Alive	Deceased	Age	Health Status or Cause of Death
Maternal Grandmother	A	D		
Paternal Grandmother	A	D		
Maternal Grandfather	A	D		
Paternal Grandmother	A	D		
Father	A	D		
Mother	A	D		
Sibling	A	D		
Sibling	A	D		
Sibling	A	D		
Sibling	A	D		

### Social History

Work in home: Occupation:	Yes	No		Employed:	Yes	No
Student:	Yes	No		Daycare:	Yes	No
Retired:	Yes	No		Married:	Yes	No
Single:	Yes	No		Separated:	Yes	No
Divorced:	Yes	No		Widowed:	Yes	No
Widowed:	Yes	No		Children:	Yes	No
Number of Children:						
Exercise: Daily	Weekly	Monthly	Rarely	Never		
Type of Exercise(s):						
Substance Abuse: Explain Usage:	Yes	No				
Smoke:	Yes	No	Packs per day:	Years:		
Quite Smoking: Packs per day:	This year		>1yr Years:	>5 yrs	>10 yrs	
Alcohol:	Daily	1-2 Weekly	1-2 Monthly	1-2 year	Never	

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Reviewed by:** \_\_\_\_\_ **Date:** \_\_\_\_\_