

# COMPREHENSIVE ORTHOPAEDIC HISTORY (PAGE1)

## CHIEF COMPLAINT

Why are you seeing the doctor today? \_\_\_\_\_

The current problem is the result of: (please circle all that apply) **Auto** **Worker's Comp.** **Other:** \_\_\_\_\_

### LIST ANY AND ALL MEDICATIONS – NOT JUST ORTHOPEDIC RELATED MEDICATIONS

Medication	Dose	Reason	Medication	Dose	Reason

DO YOU HAVE ANY ALLERGIES OR ADVERSE REACTIONS TO MEDICATIONS AND/OR SHELLFISH? **YES** **NO**

\_\_\_\_\_

Are all immunizations up to date? **Yes** **No** If no, which are due? \_\_\_\_\_

### PAST MEDICAL HISTORY – LIST ALL MEDICAL HISTORY NOT JUST ORTHOPEDIC RELATED

Surgery/Hospitalizations/Fractures	Year	Complications

Have you ever had general anesthesia? **Yes** **No** If yes, any problems with anesthesia? **Yes** **No**

### SOCIAL HISTORY

<input type="checkbox"/> Work in the home	<input type="checkbox"/> Employed (occupation _____)	<input type="checkbox"/> Student	<input type="checkbox"/> Retired
<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Separated
<input type="checkbox"/> Widowed			
Do you have children?	Yes No	How many?	1 2 3 4 5 Other: _____
Do you live alone?	Yes No	Exercise?	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Rarely <input type="checkbox"/> Never
Why type of exercise?			
History of substance abuse? Yes No		What?	
Smoke currently?	Yes No	_____ packs per day for _____ years	
Quit smoking?	<input type="checkbox"/> This year	<input type="checkbox"/> > 1 yr	<input type="checkbox"/> > 5 yrs <input type="checkbox"/> > 10 yrs- smoked _____ packs per day for yrs
Drink alcohol?	<input type="checkbox"/> Daily	<input type="checkbox"/> 1- 2 x/wk	<input type="checkbox"/> 1- 2 x/mo <input type="checkbox"/> 1- 2 x/year <input type="checkbox"/> No, I do not drink
Are YOU or have YOU ever been a victim of domestic violence? Yes No			

