

Comprehensive Orthopaedic History (page 1)

Name: _____ Today's Date: _____

SS# _____ Date of Birth: _____

Chief Complaint

Why are you seeing the doctor today? _____

Current problem is the result of a(n): Check all that apply

Car Accident Work Accident Accident Other _____ Date of Injury _____

*******LIST ANY & ALL MEDICATIONS – NOT JUST ORTHOPEDIC RELATED MEDICATIONS*******

Medication	Dose	Reason	Medication	Dose	Reason

ALLERGIES OR ADVERSE REACTIONS TO MEDICATIONS AND/OR SHELLFISH _____

NAME OF PHARMACY _____ TELEPHONE NUMBER _____

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? No Yes Have any problems with anesthesia? No Yes

Social History

Work in the home Employed (occupation _____) Student Retired

Single Married Divorced Separated Widowed Children? No Yes How many?

Do you live alone? No Yes Exercise? Daily Weekly Rarely Never

What type of exercise? _____ History of substance abuse? No Yes What? _____

Smoke currently? No Yes ____ Packs per day for ____ years.

Quit smoking? This year > 1 year >5 years > 10 years - Smoked ____ packs per day for years.

Drink alcohol? Daily 1-2 x/week 1-2 x/month 1-2 x/year No

Are YOU or have YOU ever been a victim of domestic violence? Yes No

Comprehensive Orthopaedic History (page 2)

Name: _____ Today's Date: _____

Review of Systems

Are you currently having or have you had problems with:
Describe all Yes responses

Yes	No	
		High blood pressure
		Diabetes
		Stomach ulcers
		Heart attack
		Chest pain / Tightness
		Heart disease / Murmur
		Stroke
		Cancer - Location:
		Hepatitis / Yellow Jaundice
		Glaucoma, Cataract, Eye Disorder
		HIV (AIDS virus) Exposure
		Seizure disorders / Epilepsy
		Bleeding disorders
		Tuberculosis
		Gallstones
		Kidney stones
		Abdominal bleeding
		Diverticulosis
		Thyroid problem
		Lung problem / Asthma / Shortness of breath
		Numbness / Tingling
		Swelling of joints
		Arthritis / rheumatism
		Bowel/Bladder problem
		Gout
		Circulation Disorder
		Nervous problem / Depression
		Rheumatic Fever

Height _____ Weight _____ Update _____ Wt _____ Update _____ Wt _____ Update _____ Wt _____ Update _____ Wt _____
 BMI _____ BMI _____ BMI _____ BMI _____ BMI _____

Family History

Member	Alive	Deceased	Age	Health status or cause of death
Grandmother (mom's)	A	D		
Grandfather (mom's)	A	D		
Grandmother (dad's)	A	D		
Grandfather (dad's)	A	D		
Father	A	D		
Mother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		

Patient Signature: _____ Date: _____

Reviewed by _____ MD Date ____/____/____; Updated: ____/____/____; ____/____/____; ____/____/____

_____/_____/_____; _____/_____/_____; _____/_____/_____; _____/_____/_____; _____/_____/_____; _____/_____/_____