



**ORTHOPAEDIC HISTORY**

Name \_\_\_\_\_ Date \_\_\_\_\_

SS#: \_\_\_\_\_ Date of birth: \_\_\_\_\_

CHIEF COMPLAINT: Why are you seeing the doctor today? \_\_\_\_\_

Current problem is the result of: (check all that apply)

Car accident  Work accident  Other accident  Other Date of accident: \_\_\_\_\_

Medication	Dosage	Reason for medication	Any side effects?

Date of accident: \_\_\_\_\_ Do you have any allergies?  Yes  No If yes, please list:

Are your immunizations up to date?  Yes  No If no, which immunizations are due?

## REVIEW OF SYSTEMS

Have you ever had problems with any of the items below? Please describe all YES responses.

GENERAL	NO	YES	DESCRIPTION
Fever/chills			
Weight loss/gain			
Weakness/fatigue			
<b>SKIN</b>			
Skin rash/dryness			
Moles/lumps			
Pigmentation			
<b>EYES</b>			
Blurred vision			
Eyes discharge			
Itching			
<b>EARS, NOSE, THROAT</b>			
Hearing loss			
Sinusitis			
Sore throat			
Oral cavities			
Ulcers			
<b>CARDIOVASCULAR</b>			
High blood pressure			
Chest pain			
Hypertension			
Palpitations			
<b>RESPIRATORY</b>			
Cough			
Asthma			
Wheezing			
<b>GASTROINTESTINAL</b>			
Nausea/vomiting			
Diarrhea/constipation			
Ulcer			
<b>GENTOURINARY</b>			
Painful urination			

NAME:

DOB:

TODAY'S DATE:

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	NO	YES	DESCRIPTION
Menopause			
Hernia			
Incontinence			
<b>MUSCULOSKELETAL</b>			
Arthritis			
Joint stiffness			
Swelling			
Gout			
Chronic back pain			
<b>NEUROLOGIC</b>			
Blackout/fainting			
Numbness/tingling			
Dizziness/vertigo			
Weakness/tremor			
<b>PSYCHIATRIC</b>			
Depression			
Agitation			
Panic/anxiety			
Memory disturbance			
<b>HEMATOLOGIC/LYMPHATIC</b>			
Anemia			
Bleeding problems			
Diabetes			
AIDS			
Cancer			
<b>ENDOCRINE</b>			
Thyroid disease			
Diabetes			
<b>ALLERGIC/IMMUNOLOGICAL</b>			
Allergies			
Polio			
TB			
Epilepsy			

NAME:

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Please list all past surgeries and hospitalizations:

REASON	YEAR	COMPLICATIONS?

Have you ever had general anesthesia?  yes  no

Have any problems with anesthesia?  yes  no (if **yes**, please describe)

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Family history:

	ALIVE	DECEASED	AGE	HEALTH STATUS OR CAUSE OF DEATH
Grandmother (maternal)				
Grandfather (maternal)				
Grandmother (paternal)				
Grandfather (paternal)				
Father				
Mother				
Sister/brother				
Sister/brother				
Sister/brother				
Sister/brother				

Social History:

Pre-school  Student (Grade \_\_\_\_ )  Single  Married  Working  Retired

Children?  No  Yes How many? \_\_\_\_\_

Do you live alone?  No  Yes With whom? \_\_\_\_\_

Exercise?  Daily  Weekly  Monthly  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

Previously smoked \_\_packs per day for \_\_\_\_years.

Drink alcohol?  Daily  1-2 x/week  1-2 x/month  1-2 x/year

*Thank you for your time in completing this information!*

Patient signature: \_\_\_\_\_ Date \_\_\_\_\_

Reviewed by: \_\_\_\_\_, M.D. Date \_\_\_\_\_