Orthopedic History

Name: _____ Today's Date: _____

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

___ Date of Accident ___ Other

Medication	Dose	Reason for Medication

(If additional space is needed, please list on back)

Allergies: _____

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

_____

Review of Systems

Are you currently having or have you had problems with your:

	Circle	**Describe all Yes Responses**
Eyes	No Yes	_____
Ears,Nose,Throat	No Yes	_____
Lungs, Breathing	No Yes	_____
Bowel Movement	No Yes	_____
Bladder Problem	No Yes	_____
Heart Disease/Heart Attack	No Yes	_____
Stroke	No Yes	_____
Diabetes	No Yes	_____
High blood pressure	No Yes	_____
Bleeding problems	No Yes	_____
Balance Problems	No Yes	_____
Numbness/tingling	No Yes	_____
Blackout/fainting	No Yes	_____
Psychological	No Yes	_____
AIDS	No Yes	_____
Cancer	No Yes	_____
Arthritis	No Yes	_____
Polio	No Yes	_____
TB	No Yes	_____
Epilepsy	No Yes	_____

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Name: _____ Today's Date: _____

Past Medical History

Surgeries/Hospitalizations	Year	Complications

Have you ever had general anesthesia? No Yes
Have any problems with anesthesia? No Yes Describe _____

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		

Social History

___Work in the Home ___Employed (Occupation _____) ___Student ___Retired

___Single ___Married ___Divorced ___Separated ___Widowed

Children ___ 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 ___≥ Year ___ ≥ 5Years ___ ≥ 10 Years

Previously smoked ____ packs per day for ___ years

Drink alcohol? ___None ___Daily ___1-2 x/week ___1-2x/month ___1-2x/year

Patient signature: _____ **Date**: _____

Reviewed by: _____ **Date**: _____