

Orthopedic History (Page 1)

Name: _____ today's Date _____
 Medical Record # _____ 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: _____

This occurred during: **Check** all that apply

- lifting pulling pushing twisting falling bending
 reaching squatting hit by object not known

Medication	Dose	How long?	Side effects?

ALLERGIES:

Review of Symptoms

Are you currently having or have you had problems with you're:

	Circle		describe all YES responses
Eyes	No	Yes	_____
Ears, nose, throat	No	Yes	_____
Lungs, breathing	No	Yes	_____
Digestions	No	Yes	_____
Bowel movement	No	Yes	_____
Bladder problem	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 problems	No	Yes	_____
AIDS	No	Yes	_____
Cancer	No	Yes	_____
Arthritis	No	Yes	_____
Polio	No	Yes	_____
TB	No	Yes	_____
Epilepsy	No	Yes	_____

Orthopedic History (Page 2)

Name: _____ today's Date: _____
 Medical record # _____

Past Medical History

Surgeries / Hospitalizations	Year	Complications

Have you ever had general anesthesia? No yes
 Have you had 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 home employed (occupation _____) student
 Single married divorced separated widowed
 Children no yes # of children _____
 Do you live alone? No yes
 Exercise? Daily weekly rarely never
 What type of exercise? _____
 Are you on a special diet? No yes describe: _____
 History of substance abuse? No yes what? _____
 Smoking currently? No yes _____ packs per day for _____ years
 Previously smoked _____ packs per day for _____ years
 Drink alcohol? Daily 1-2x/week 1-2x/month 1-2x/year
 Reviewed by: _____ MD Date: _____