Current History Form

COG #

All questions contained in this questionnaire are strictly confidential and will become part of your medical record. It is very important that you clearly tell us your current or past history as this assists the physicians in understanding your problem and executing the best care and outcome for your current condition.

Name: ______________________ Today's Date: ____________

Date of Birth: ____________________ Sex ○ Male ○ Female

Age: _____ Ht: _______ Wt: ________ Your Occupation? ______________________

Referring Doctor: ______________ Primary Care Doctor ______________

Please darken the circles like this...

Your Chief Complaint: ______________________________________

How long have you had this problem?

1-2	3-5	6-8	9-12	days	weeks	months	years
○	○	○	○	○	○	○	○

choose one (1-2 / 3-5 / 6-8 / 9-12) — choose one (days / weeks / months / years)

HISTORY OF THE PRESENT CONDITION

Date of this onset? ______________ Ever had this before? ○ Yes ○ No Date? __________

Was this an injury (accident)? ○ Yes ○ No

Is your injury work / job related? ○ Yes ○ No Last date you worked? ______________

Are you left or right handed? ○ Left ○ Right

State in your own words how the present problem happened and what you felt at the time:

COLUMBIA ORTHOPAEDIC GROUP

Past Medical History

COG #

Fill in the circles if you have had any of the following problems.

O Coronary Artery Disease	O Kidney disease/Stones	O Cancer....type of ( )
O Heart Failure	O Prostate problems	O Allergy to anesthesia
O High Blood Pressure	O Thyroid Disease	O Drug/Alcohol Addiction
O Hardening of the arteries	O Stomach Ulcers	O Ear, Nose, Throat problems
O Blood Clots	O Gastro-intestinal Reflux	O Sleep Apnea/CPAP
O Lung/breathing problems	O Liver problems/Hepatitis	O Osteoporosis
O Neurological problems	O Tuberculosis	O Rheumatoid Arthritis
O Depression	O Diabetes	O Osteoarthritis
O Incontinence	O Stroke	O HIV/AIDS

Past Surgical History

Please indicate all previous surgeries you have had.

Year	Procedure Done	Surgeon's name.../and where?

Current Medications

Please list all prescription and over-the -counter medicines

Name	Name	Name

Allergies to Medications, foods or other substances

Name the medication/item	Indicate the reaction you had

Mark if allergic to: O Metals O Shellfish/Iodine O Latex O IVP Dye O Steroids O Aspirin

Do you have any metal implants, infusion catheters, surgical clips or pacemaker? O Yes O No

Family Medical History

COG #

Fill in circles if any of the following exist in your family or relatives.

O Arthritis	O Peripheral Vascular Disease	O Psychiatric Problems	O Cancer
O Osteoporosis	O Stroke	O Kidney Failure	O Bleeding Problems
O Diabetes	O Neurological problems	O Kidney Stones	O Tuberculosis
O Heart Failure	O Seizures	O Incontinence	O Other( )

Social History

Marital Status:	O Single	O Married	O Divorced	O Widowed	
Education:	O Some High school	O High School Grad	O College	O Post Grad	
Employment:	O Currently working	O Seeking work	O Disabled	O Retired	O Other
Exercise:	O Sedentary	O Mild	O Moderate	O Vigorous	
Tobacco:	O Never used	O Former smoker	O I smoke	O I chew	
Alcohol:	O Never	O Occasional	O Frequently		
Pregnant:	O Yes	O No	O Planning	O Sterile	
My health is:	O Excellent	O Very Good	O Good	O Fair	O Poor

Review of Systems

fill in circle if you have had any of the following in the last 2 weeks

O Headaches	O Leg numbness	O Heart or chest pain	O Depressed
O Seizures	O Leg cramps	O Shortness of breath	O Anxious
O Visual changes	O Loss of bladder control	O Difficulty swallowing	O Recent Falls
O Arm weakness	O Loss of bowel control	O Joint swelling	O Dizziness
O Arm numbness	O Ulcers/Reflux	O Chills/Fever	O Dry Skin/Sores
O Leg weakness	O Nausea	O Insomnia (trouble sleeping)	O Night Sweats

...Thank you from the Columbia Orthopaedic Group