

ORTHOPAEDIC HISTORY FORM

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Date _____

Referred by _____

Name (Print) _____ Age _____ Birthdate _____

Address (Home) _____ City _____ Zip _____ Home Phone: _____

(Business) _____ City _____ Zip _____ Bus. Phone: _____

Height: _____ Weight: _____ Right/Left Handed (circle) Occupation: _____

Spouse's Name _____

The medical history included here can be of critical importance to you and your physician. Please answer the following items as accurately as possible.

Current Condition

Please Print or Write Answer

For what condition or problem are you being seen at this time?	
When did the injury occur or when did the symptoms or condition first begin?	
How did the injury occur or how did the symptoms develop and progress?	
What treatment , if any, have you had? Has this helped?	
Is this new or have you had similar symptoms in the past? Please describe.	

Illnesses: Do you have or have you had any of the following illnesses/conditions?

YES NO

- Heart disease
- Heart attack
- Irregular heartbeat
- High blood pressure
- Stroke
- Blood clots

YES NO

- Kidney disease
- Liver disease
- Ulcers/gastritis
- Colitis
- Chronic infections
- Cancer

YES NO

- Lung disease
- Asthma
- Neurologic disease
- Mental illness
- Diabetes
- Arthritis

YES NO

- Emotional disorder
- Bleeding problems
- Anemia
- Skin problems
- Hernia
- Other _____

Medications:

Dose/Amount

Frequency

Allergies or Medication Intolerances:

Surgery/Hospitalizations:

When or at what age?

Social History:

Marital Status: Single ___ Married ___ Other ___
 Alcohol: None ___ Occasionally ___ Regularly ___ Excessively ___
 Tobacco: None ___ Yes (packs/day) ___
 Coffee: None ___ Yes (cups/day) ___
 Harmful Substances: _____

Family History:

	Age	Diseases/Conditions or Cause of Death if Deceased
Father	_____	_____
Mother	_____	_____
Brother(s)	_____	_____
Sister(s)	_____	_____
Other(s)	_____	_____

System Review:

Please circle any of the following symptoms you have and list any not included:

General: Recent weight loss; fever; chills; sleep disorder

Eyes/Vision: Loss or change of vision; double vision; blurred vision; eye diseases; redness; watering

Ears, Nose, Throat: Hearing loss; ringing in the ears; ear infections; nose bleeds; sinus drainage; hay fever; hoarseness; difficulty swallowing; sore throat

Respiratory/Lungs: Wheezing; shortness of breath; frequent or chronic cough; coughing up blood

Cardiovascular: Chest pain; irregular/abnormal heartbeat; palpitations; high blood pressure; varicose veins; cramping in the legs; swelling of the feet/ankles; blood clots

Gastrointestinal: Nausea; vomiting; abdominal pain; indigestion; diarrhea/loose stools; constipation; blood in the stool

Genitourinary: Frequent urination; painful urination; excessive urination; bladder/kidney infections; kidney disease; bloody urine; testicular pain

Neurologic: Headaches; seizures; convulsions; tremors; sciatica; numbness in the arms or legs; loss of consciousness: blacking out; memory loss; dizziness; other: _____

Psychologic/Emotional: Nervousness; depression; sleep disorder or insomnia; mental illness

Endocrine: Hormone problems; thyroid disorder; heat or cold intolerance; diabetes; excessive thirst; swollen glands

Hematologic/Lymphatic: Easy bruising; excessive bleeding; anemia; lumps or bumps; lymphedema

Other (not listed above): _____

Signature of patient, parent or guardian

Signature of physician

Date