ORTHOPAEDIC HISTORY FORM

Drs. Hayashi, Dahms, Durand, Pattee

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.	

Please circle any of the following illnesses you have had or now have and explain below. Also list any not included:

Heart disease	Kidney disease	Neurologic disease	Emotional disorder
Heart attack	Liver disease	Mental illness	Bleeding problems
Irregular heartbeat	Ulcers/gastritis	Chronic infections	Anemia
High blood pressure	Colitis	Cancer	Skin problems
Stroke	Lung disease	Diabetes	Hernia
Blood clots	Asthma	Arthritis	Other ______________________

Explain:____
____

Surgery/Hospitilizations:

When or at what age?

____ ____________________
____ ____________________
____ ____________________
____ ____________________

Allergies/Medication Intolerances:

____
____

Medications

	Dose/Amount	Frequency
____	________________	______________
____	________________	______________
____	________________	______________
____	________________	______________

Social History

Marital Status: Single _____ Married _________ Other ________
Alcohol: None _____ Occasional _____ Regularly _____
Tobacco None _____ Yes (packs/day) ________
Coffee None _____ Yes (cups/day) _________
Harmful Substances/Drugs ____

Family History

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

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

Gatrointestinal: 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

Psychological/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 or excessive bleeding; anemia; lumps or bumps; lymphedema

Other (not listed above):
____
____
____

Please detail any other health information or conditions:
____
____
____

____ ______________________
Signature of patient, parent or guardian **Date**

____ ______________________
Signature of physician **Date**

7/06