Orthopedic History (Page 1)

Name: _____ Today's Date: _____

SS#: _____ 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

Medication	Dose	Reason For Medication	Side Effects

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	
Digestion	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	

Patient Signature: _____ **Date:** _____

Reviewed By: _____ **MD** **Date:** _____

Orthopedic History (Page 2)

Name: _____ Today's Date: _____

SS#: _____ Date of Birth: _____

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 ☐ Daycare ☐ Retired

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Children? ☐ No ☐ Yes #_____

Do you live alone? ☐ No ☐ Yes _____

Exercise? ☐ Daily ☐ Weekly ☐ Monthly ☐ 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 ☐ >1 year ☐ >5 years ☐ >10 years

Previously smoked ____ packs per day for ____ years.

Drink alcohol? ☐ Daily ☐ 1-2 x/week ☐ 1-2 x/month ☐ 1-2 x/year

Patient Signature: _____ **Date:** _____

Reviewed By: _____ **MD** **Date:** _____