

ORTHOPAEDIC MEDICAL HISTORY

NAME: _____

TODAY'S DATE: _____

DATE OF BIRTH: _____

PRIMARY CARE PHYSICIAN: _____

CHIEF COMPLAINT

WHY ARE YOU SEEING THE DOCTOR TODAY? _____

Medication	Dose	Reason for Medication	Side Effects

ALLERGIES:

REVIEW OF SYSTEMS

Are you currently having or have had problems with your:

	Circle	If Yes, describe:
Eyes, Ears, Nose, Throat	No Yes	_____
High Blood Pressure	No Yes	_____
Heart Attack	No Yes	_____
Chest Pain/ Angina	No Yes	_____
Asthma/ Emphysema	No Yes	_____
Ulcers/ Intestinal Disease	No Yes	_____
Hepatitis/ Jaundice	No Yes	_____
Prostate/ Kidney/ Bladder	No Yes	_____
Stroke/ Epilepsy/ Seizures	No Yes	_____
Bleeding Problems	No Yes	_____
Blood Clots	No Yes	_____
Anemia	No Yes	_____
Diabetes	No Yes	_____
Thyroid	No Yes	_____
Arthritis	No Yes	_____
Back Pain	No Yes	_____
Osteoporosis	No Yes	_____
AIDS/ HIV	No Yes	_____
Cancer	No Yes	_____

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NAME: _____

PAST MEDICAL HISTORY

Reasons for Surgery/ Hospitalization	Year	Complications

Circle

Have you ever had general anesthesia? No Yes

Have any problems with anesthesia? No Yes Describe: _____

FAMILY HISTORY

Do any of your immediate family members have problems with:

	Circle	
Heart Disease	No Yes	If Yes, describe: _____ _____ _____ _____ _____ _____ _____
Stroke	No Yes	
Bleeding Problems	No Yes	
Diabetes	No Yes	
Cancer	No Yes	
Bone or Joint Problems	No Yes	
Orthopaedic Disease of Childhood	No Yes	
Other _____	No Yes	

SOCIAL HISTORY

__ Employed (occupation _____) __ Student __ Unemployed __ Disabled __ Retired

__ Single __ Married __ Divorced __ Separated __ Widowed

Children? __ No __ Yes # _____

Do you live alone? __ No __ Yes

Exercise? __ Daily __ Weekly __ Rarely __ Never

What type of exercise? _____

Smoke currently? __ No __ Yes ___ Packs Per day for ___ years

Quit smoking? __ This year/ <1 year __ 1-5 years __ > 5 years __ >10 years

Previously smoked ___ Packs Per day for ___ years

Drink alcohol? __ None __ Daily __ 1-2 x/week __ 1-2 x/month __ 1-2 x/year Quantity _____

History of substance abuse? __ No __ Yes What? _____

PATIENT / GUARDIAN SIGNATURE: _____

To Be Completed By Nurse:		
Vital Signs	Pulse	Height
	Blood Pressure	Weight
Reviewed By: _____	MD	Date: _____