



**Orthopaedic History**  
**Page #1**

Patient's name: \_\_\_\_\_ Today's date: \_\_\_\_\_

S.S. #: \_\_\_\_\_ Date of birth: \_\_\_\_\_

**CHIEF COMPLAINT**

Why are you seeing the doctor today? \_\_\_\_\_

Your 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 your 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 problems	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	_____

# Orthopaedic History

## Page #2

Patient's name: \_\_\_\_\_ Today's date: \_\_\_\_\_

S.S. #: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Psychological problems	NO	YES	
AIDS	NO	YES	
Cancer	NO	YES	
Arthritis	NO	YES	
Polio	NO	YES	
TB	NO	YES	
Epilepsy	NO	YES	

### PAST MEDICAL HISTORY

Surgeries/Hospitalizations	Year	Complications

Have you ever had general anesthesia?     Yes     No  
 Have you had problems with the anesthesia?     Yes     No    Describe: \_\_\_\_\_

### FAMILY HISTORY

Member	Alive	Deceased	Age	Health Status/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		

**Orthopaedic History**

**Page #3**

Patient's name: \_\_\_\_\_ Today's date: \_\_\_\_\_

S.S. #: \_\_\_\_\_ Date of birth: \_\_\_\_\_

**SOCIAL HISTORY**

Retired    Student    Employed (occupation) \_\_\_\_\_  Work in the home

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.

**REFERRING PHYSICIANS**

PCP: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Fax: \_\_\_\_\_

**SPECIALISTS**

Physician: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Fax: \_\_\_\_\_

Physician: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Fax: \_\_\_\_\_