

## Orthopedic History

*This information will help your doctor to understand your problem. Please complete the form as completely as possible. If you have any questions, do not hesitate to ask your doctor.*

Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Today's Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### Chief Complaint

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

This problem is the result of a(n) (please check all that apply):

car accident                  work accident                  other accident  
other (please explain) \_\_\_\_\_  
\_\_\_\_\_ )

### Past Medical History

Please list any surgeries or hospitalizations, date, and any complications:

Surgeries/Hospitalizations	Year	Complications
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever had problems with general anesthesia?    Yes    No (describe: \_\_\_\_\_)

What medications are you currently taking?

Medication	Dose	Reason for Medication	Side Effects
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Please list any allergies you have:** \_\_\_\_\_

Are all of your immunizations up-to-date?    Yes    No  
If no, which immunizations are due? \_\_\_\_\_

**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Reviewed By:** \_\_\_\_\_, MD/DO **Date:** \_\_\_\_\_

## Orthopedic History, Continued

Name: \_\_\_\_\_ Today's

Date: \_\_\_\_\_

### Family History

Member	Alive	Deceased	Age	Health Status or cause of death
Maternal grandmother	A	D		
_____				
Maternal grandfather	A	D		
_____				
Paternal grandmother	A	D		
_____				
Paternal grandfather	A	D		
_____				
Father	A	D		
_____				
Mother	A	D		
_____				
Brother/Sister	A	D		
_____				
Brother/Sister	A	D		
_____				
Brother/Sister	A	D		
_____				
Brother/Sister	A	D		
_____				

### Social History

What is your occupational status? Work in the home    Employed    Student    Day Care    Retired  
 If you work outside the home, what is your occupation?

\_\_\_\_\_

What is your marital status?    Single    Married    Divorced    Separated    Widowed  
 Do you have children?    Yes    No    If yes, how many? \_\_\_\_\_ Do you live alone?    Yes  
 No

How often do you exercise?    Daily    Weekly    Monthly    Rarely    Never  
 If you exercise, what type of exercise do you do?

\_\_\_\_\_

Do you have a history of substance abuse?    Yes    No    If yes,  
 what? \_\_\_\_\_

Do you smoke?    No    Yes, \_\_\_\_\_, packs a day for \_\_\_\_\_ years.  
 Have you quit smoking?    This year    1-5 years    5-10 years    more than 10 years  
 N/A

Previously smoked \_\_\_\_\_ packs a day for \_\_\_\_\_ years.  
 Do you live with someone who smokes    Yes    No

Do you drink alcohol?    Yes    No  
 If yes, how often?    Daily    1-2 times per week    1-2 timer per month    1-2 times a year

**Review of Systems**

Please check any that you have had or are currently having problems with:

Eyes	Lungs/Breathing	Digestion	AIDS	Bowel Movement
Bladder	Diabetes	Polio	Cancer	Ear/Nose/Throat
TB	Epilepsy	High Blood Pressure		Bleeding Problems
Balance Problems		Numbness		Blackout/Fainting
Psychological Problems		Arthritis		

Please explain or describe any that apply to you:

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