

Orthopedic History Sheet

Today's Date: _____

Patient Name: _____ **Age:** _____ **Dominant Hand:** Right Left

What are you seeing the doctor for today? _____

If this is a re-visit to our office for a new problem, list any changes to your health, medicines, or allergies since previously seen. _____

Date of Injury/Onset: _____ On which side is the injury? Right Left

Please describe how your injury happened. _____

Have you been treated by anyone else for this problem? Yes No

If yes, by whom, when and where were you treated? _____

Did you have X-rays taken? Yes No Where? _____

Were you put on any medication for this problem? Yes No

If yes, what type of medication and are you taking it now? _____

What increases your pain or symptoms? _____

What decreases your pain or symptoms? _____

What is your current work status? No Restriction Working w/Restriction
 Off Duty Disabled Unemployed Homemaker Retired

If you are not working, what was your last day at work? _____

Family History (*These questions apply to your mother, father, brother, sister, or child.*)

	Please Specify:	M	F	B	S	C
Family history of arthritis?						
Family history of bone disease?						

Please list previous hospitalizations and/or surgeries:

If you have any questions about this form, or if there is other information which you have or which you feel might be important, please discuss it with the doctor. Also, if any of the information that you have provided should change, please inform the doctor. Thank you, Community Orthopedic Surgery

MEDICAL HISTORY	Yes	No	MEDICAL HISTORY	Yes	No	MEDICAL HISTORY	Yes	No
Chronic cough or lung problems			Chronic back problems			Circulation problems		
Shortness of breath at rest			Excess bleeding from surgery			Hard of hearing		
Shortness of breath w/exercise			History of anemia (low blood count)			Wear glasses/contact lenses		
Recent cold, bronchitis or pneumonia			Diabetes, since:			Problems walking		
History of asthma or wheezing			Liver disease/jaundice/hepatitis			Chemotherapy		
High blood pressure - how many yrs?			Kidney disorder			Immunizations up-to-date		
Heart attack - Date:			Stomach ulcer			History of motion sickness		
Heart failure - Date:			Chronic heartburn			Are you on a special diet		
Chest discomfort/tightness w/exercise			Hiatal hernia			Problems chewing/swallowing		
Irregular heartbeat - Date:			Transfusion - Date:			Depression/Psychiatric condition		
Mitral valve prolapse			Could you be pregnant			Substance abuse		
Heart murmur			Date last menstrual period:			Alcohol drinks per week:		
Stroke/TIA/weakness/paralysis			Dentures/bridges/caps			Years smoked: packs/day		
Epilepsy/seizure - Date last seizure:			Skin problems			Date stopped smoking:		
Sleep Apnea								
Exam by cardiologist (heart doctor)			If yes, Dr's name/city:			Year:		
Heart catheterization			If yes, where			Year:		
Exercise stress test			If yes, where			Year:		
Ultrasound of heart (echocardiogram)			If yes, where			Year:		
Pacemaker			If yes, where			Year:		

ARE YOU ALLERGIC TO:	Yes	No	Reaction	Do you have or have you ever had any of the following:		
Latex				Arthritis	Y	N
Any food				Blood clots	Y	N
Adhesive tape				Cancer	Y	N
Iodine on your skin				Injury with long-term impairment	Y	N
Medication Allergies?			<i>If yes, list drug and reaction below.</i>	Joint pain	Y	N
1)				Numb arm or leg	Y	N
2)				Pulmonary embolism	Y	N
3)				Rheumatoid arthritis	Y	N
4)				Thyroid disease	Y	N
5)				Keloids	Y	N
				Lupus	Y	N

HEIGHT: _____

WEIGHT: _____

Please List All Prescription and Non-Prescription Medications you are presently taking, including dosage and frequency. Include non-prescription medications, such as iron, aspirin, antacid, laxatives, eyedrops, vitamins and herbal supplements.

Medication - Dose - Times Per Day Taken	Medication - Dose - Times Per Day Taken	Medication - Dose - Times Per Day Taken
1)	6)	11)
2)	7)	12)
3)	8)	13)
4)	9)	14)
5)	10)	15)

Signature of Patient _____

Today's Date _____

7/23/2009