ORTHOPEDIC HISTORY (Please Complete Both Sides)

Name: ____________________________________ Today's Date: ______/______/______

SS#: ______________________________________ Date of Birth: ______/______/______

Why are you seeing the doctor today? ____

Current problem is a result of a(n): Check all that apply

- __ Motor Vehicle Accident
- __ Work Accident
- __ Accidental Injury
- __ Other

MEDICATIONS

MEDICATION	DOSE	REASON FOR MEDICATION	SIDE EFFECTS

ALLERGIES: (Medications, Anesthesia, and/or Adhesive tape)
Please list with type of reaction

____

____

____

____

REVIEW OF SYSTEMS

Are you currently having or have you had problems with:

	CIRCLE		Describe if Yes
Arthritis	No	Yes	______________________________
Balance Problems	No	Yes	______________________________
Blackouts/ Fainting	No	Yes	______________________________
Bleeding Problems	No	Yes	______________________________
Cancer	No	Yes	______________________________
Chronic Infections	No	Yes	______________________________
Coronary Disease	No	Yes	______________________________
Diabetes	No	Yes	______________________________
Digestive Disorders	No	Yes	______________________________
Epilepsy	No	Yes	______________________________
Gout	No	Yes	______________________________
Hepatitis	No	Yes	______________________________
High Blood Pressure	No	Yes	______________________________
Immune Deficiency	No	Yes	______________________________
Kidney/Bladder	No	Yes	______________________________
Lungs, Breathing	No	Yes	______________________________
Phlebitis	No	Yes	______________________________
Scoliosis	No	Yes	______________________________
TB	No	Yes	______________________________

PAST MEDICAL HISTORY

Surgeries/Hospitalization	Year	Complications

Have you ever had general anesthesia? No Yes
Have you had problems with anesthesia? No Yes Describe ___________________________________

FAMILY HISTORY

	Alive	Deceased	AGE	HEALTH CONDITION/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		

SOCIAL HISTORY

Age: __________ Height: __________ Weight:__________

Occupation: ____

Are you ____Right Handed ____ Left Handed

Do you live alone? (Circle) No Yes

Do you exercise?(Circle) No Yes ***Describe Exercise/Activity*** ____________________________________

Smoke Currently? (Circle) No Yes #_______ Packs per day for _______ years.

Drink Alcohol? ____ Daily ____ 1-2x/week ____ 1-2x/month ____ 1-2x/year

Other habits, please describe ____

How were you referred to our Office? ____

Patient's Signature ____ Date ______/______/______

Reviewed By ____ Date ______/______/______