ORTHOPEDIC HISTORY

Name ______________________ Date of Birth ______________

☐ Male ☐ Female ☐ Right-handed ☐ Left-handed

Occupation ______________________

When did the problem start ______________________

Is your present complaint due to an injury sustained while at work? ☐ Yes ☐ No

Is your present complaint due to a motor vehicle accident? ☐ Yes ☐ No

Please describe the problem that brought you here ______________________

Which side of the body is injured: ☐ Right ☐ Left ☐ Both

If unable to work, please give dates: from: __________ to __________

Type of pain ☐ Dull ☐ Sharp ☐ Burning ☐ Constant ☐ Radiating

Have you experienced (check all that apply) ☐ Clicking ☐ Swelling ☐ Locking ☐ Buckling ☐ Stiffness ☐ Weakness ☐ Difficulty using stairs

Any numbness or tingling ______________________

Does the pain wake you at night ______________________

What makes it better ______________________

What makes it worse ______________________

Does the pain radiate to any other location? ☐ Yes ☐ No Where? __________

Rate your pain from 1-10 (10 being the most severe) __________

Have you had any problem with this part of your body in the past? ☐ Yes ☐ No

Explain ______________________

Are you taking any medication for this problem ______________________

Describe any treatment thus far ______________________

Have you consulted any other physicians for this problem? ☐ Yes ☐ No

If yes, who? ______________________

PLEASE CHECK ANY CONDITIONS THAT YOU HAVE CURRENTLY OR HAVE HAD IN THE PAST:

- ☐ Anemia (bleeding disorder)
- ☐ Asthma
- ☐ Cancer
- ☐ Cataract
- ☐ Depression
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Disease
- ☐ Heart Murmur/Palpitations
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ HIV/AIDS
- ☐ Kidney disease
- ☐ Liver Disease
- ☐ Lung Problems
- ☐ Lyme Disease
- ☐ Mental Disorder
- ☐ Phlebitis
- ☐ Rheumatoid arthritis
- ☐ Seizures or Epilepsy
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Ulcer
- ☐ Venereal Disease

Please list other medical problems ____________________

FAMILY HISTORY:

Does anyone in your immediate family suffer from any of the conditions listed above? ☐ Yes ☐ No
If so, what ____________________

PLEASE LIST ALL MEDICATIONS:

1. ____________
2. ____________
3. ____________
4. ____________
5. ____________
6. ____________
7. ____________
8. ____________
9. ____________
10. ____________

Have you had any surgery in the past? ☐ Yes ☐ No

Please list ____________________

List allergies ____________________

Are you pregnant ☐ Yes ☐ No

Do you smoke ☐ Yes ☐ No If so, how much ____________________

Do you drink alcohol ☐ Yes ☐ No

If yes, how much: ☐ Rarely ☐ Socially ☐ 1 drink a day ☐ 2-3 drinks a day ☐ 4 drinks or more a day

What is your occupation ____________________

Are you currently working ☐ Yes ☐ No If not, when did you last work ____________________

Is there anything else you would like to add ____________________

Patient Signature ____________________ Date__________

MD Signature ____________________ Date__________

Orthopedic History 11-08 DM/js