

**Department of Orthopaedics
Patient History Form
Please Complete Pages 1 and 2**

Patient Name _____ Age _____ Today's Date _____

Orthopaedic Problem _____ Date of Onset/Injury _____ Height _____ Weight _____

1. Do you have any food allergies? Yes No If yes, please list _____

2. Do you have a known latex allergy? Yes No

3. Do you have any medication allergies? Yes No If yes, please list _____

4. Please list any significant medical history with dates _____

5. Please list all medications you are currently taking with dosage (including over the counter medications, vitamins & herbals):
ON SECTION 'D' OF THE OUTPATIENT SUMMARY LIST. (See attached form)

6. Please list all surgeries/hospitalizations/fractures and dates _____

7. Do you smoke? Yes No If yes, how much per day? _____
Have you ever smoked? Yes No If yes, when did you quit? _____

8. Do you drink alcohol? Yes No If yes, how much and how often? _____

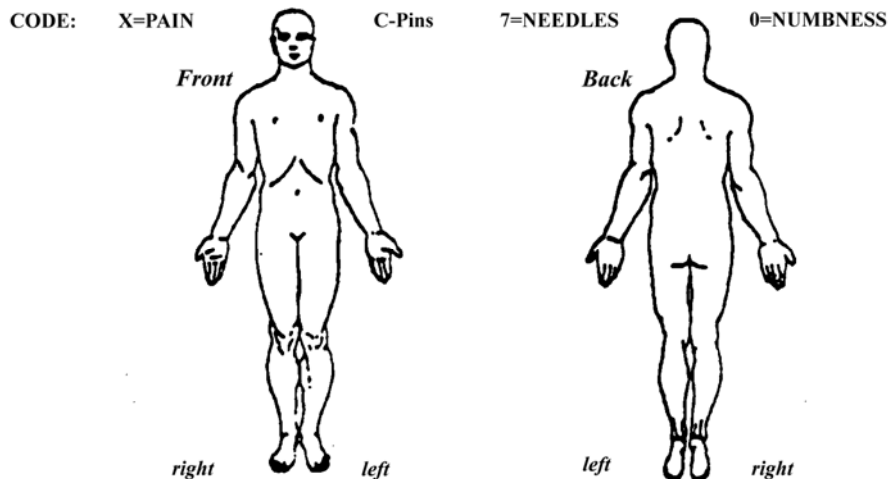
9. Significant family medical history _____

10. Who is available to help at home? _____

11. Please rate the intensity of your pain (please circle):

No pain 1 2 3 4 5 6 7 8 9 10 Worse pain ever

12. Please describe your pain on the drawing below:



13. Do you currently have or do you have a history of any of the following conditions? If yes, Please list dates.

Allergic Reaction	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Anorexia/Bulemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Asthma/Breathing Difficulties	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Bowel/Bladder Difficulties	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Chest Pain/Angina	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Circulation Disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Depression/Psychiatric Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Dizziness/Fainting	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Foot Ulcers	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Fractures	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Heart Disease of Heart Attack	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Heart Palpitations/Arrhythmias	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Hernia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Kidney Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Liver/Gall Bladder Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Lung Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Malnutrition	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Metal Implants	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Osteoporosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Pregnancy (currently)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Problems with Eyesight/Hearing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Pulmonary Embolism	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Skin Abnormalities	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Stomach Ulcers	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Stroke/Transient Ischemic Attack	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Substance Abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Thyroid Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____

If yes to any of the above, please explain briefly:

Patient/Responsible Party Signature/ Date
Revised 04/19/10

Physician Signature/ Date