Advanced Bone & Joint
ORTHOPEDIC HISTORY

Name _____ Birth Date _____ Gender ____ Referring Physician_____

Height / Weight_____Pharmacy Name / Phone: _____

HISTORY of CURRENT PROBLEM

Describe reason for visit:_____

When did the problem start?_____ How did the problem start? _____

Current problem is the result of a(n): **Check** all that apply ☐ Motor Vehicle Injury ☐ Work Injury ☐ Sports Injury

What tests have you had for this problem? ☐ X-Ray ☐ MRI ☐ Other _____

What treatments have you had for this problem?_____

What type of work do you do?: _____

PAIN RATING

Are you experiencing pain? ☐ Yes ☐No Describe the pain. _____

Please circle the number that represents the amount of pain you are having today:

(no pain)	0	1	2	3	4	5	6	7	8	9	10	(worst pain of your life)

Does it disturb your sleep? ☐ Yes ☐ No

What makes it feel better?_____ Worse? _____

PAST MEDICAL HISTORY

Sleep apnea?	☐ Yes	☐ No	Anesthetic difficulties?	☐ Yes	☐ No
Reflux?	☐ Yes	☐ No	Cancer?	☐ Yes	☐ No
Taking blood thinner medication?	☐ Yes	☐ No	Rheumatoid arthritis?	☐ Yes	☐ No
High Blood Pressure?	☐ Yes	☐ No	Blood Clot / Pulmonary Embolism?	☐ Yes	☐ No
Coronary artery disease?	☐ Yes	☐ No	Osteoporosis?	☐ Yes	☐ No
Congestive heart failure?	☐ Yes	☐ No	Gout?	☐ Yes	☐ No
Asthma?	☐ Yes	☐ No	Kidney disorders?	☐ Yes	☐ No
COPD?	☐ Yes	☐ No	High Cholesterol?	☐ Yes	☐ No
Hepatitis C?	☐ Yes	☐ No	Hypothyroidism?	☐ Yes	☐ No
HIV?	☐ Yes	☐ No	Hyperthyroidism?	☐ Yes	☐ No
Diabetes?	☐ Yes	☐ No	Other : _____		

PAST SURGICAL HISTORY **Please list all major surgeries and when performed (use the bottom for additional procedures)**

1._____ 2._____

3._____ 4._____

5. _____ 6. _____

FAMILY HISTORY

			FAMILY MEMBER with HISTORY			
Cancer	☐ Yes	☐ No	☐Mother	☐Father	☐Sister	☐Brother
Heart Disease	☐ Yes	☐ No	☐Mother	☐Father	☐Sister	☐Brother
Hypertension	☐ Yes	☐ No	☐Mother	☐Father	☐Sister	☐Brother
Osteoarthritis	☐ Yes	☐ No	☐Mother	☐Father	☐Sister	☐Brother

Other: _____

SOCIAL HISTORY

Alcohol use	☐Yes ☐	No	drinks/week____
Smoking	☐Yes ☐	No	packs/day_____
Drug use	☐Yes ☐	No	

CANCER SCREENING HISTORY (as applicable)

Last date of Mammogram Screening:_____

Last date of Cervical Screening: _____

Last date of Colonoscopy: _____

(Please continue on next page)

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ORTHOPEDIC HISTORY

«PatientNumber»

REVIEW of SYSTEMS

Systemic Symptoms

Weight change	☐ Yes	☐ No
Chills / Fever	☐ Yes	☐ No
Night sweats	☐ Yes	☐ No
Feeling tired or poorly	☐ Yes	☐ No

HEENT Symptoms

Headache	☐ Yes	☐ No
Eyesight problems	☐ Yes	☐ No
Nosebleed	☐ Yes	☐ No

Genitourinary Symptoms

Blood in urine	☐ Yes	☐ No
Painful urination	☐ Yes	☐ No
Increased urinary frequency	☐ Yes	☐ No

Skin Symptoms

Skin infections	☐ Yes	☐ No
Skin lesions	☐ Yes	☐ No
Rashes	☐ Yes	☐ No

Endocrine Symptoms

Excessive sweating	☐ Yes	☐ No
Excessive thirst	☐ Yes	☐ No
Sleep disturbances	☐ Yes	☐ No

Psychological Symptoms

Sleep disturbances	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No
Depression	☐ Yes	☐ No

Pulmonary Symptoms

Shortness of breath	☐ Yes	☐ No
Cough	☐ Yes	☐ No
Coughing up blood	☐ Yes	☐ No
Wheezing	☐ Yes	☐ No

Cardiovascular Symptoms

Chest pain or discomfort	☐ Yes	☐ No
Fast heart rate	☐ Yes	☐ No
Palpitations	☐ Yes	☐ No

Gastrointestinal Symptoms

Difficulty swallowing	☐ Yes	☐ No
Heartburn	☐ Yes	☐ No
Vomiting	☐ Yes	☐ No
Abdominal pain	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No

Hematological Symptoms

Easy bleeding	☐ Yes	☐ No
Easy bruising tendency	☐ Yes	☐ No
Blood Clots / Pulmonary Embolism	☐ Yes	☐ No

Neurological Symptoms

Dizziness	☐ Yes	☐ No
Vertigo	☐ Yes	☐ No
Loss of strength	☐ Yes	☐ No
Sensory disturbances	☐ Yes	☐ No

Other: _____

CURRENT MEDICATION(S)

Name of Medicine	Dose

Name of Medicine	Dose

ALLERGIES

Name of Medicine/Substance	Type of Reaction

Are you allergic to latex? ☐ Yes ☐ No ☐ I don't know

Other information that can help us care for you? : _____

_____ _____

Patient/Guardian Signature Date